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2d Session

HOUSE OF REPRESENTATIVES

REPORT
102-1023

HEALTH INSURANCE CLAIMS FAIRNESS ACT OF 1992

OCTOBER 5, 1992.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. FORD of Michigan, from the Committee on Education and Labor, submitted the following

REPORT

together with

MINORITY VIEWS

[To accompany H.R. 1602]

[Including cost estimate of the Congressional Budget Office]

The Committee on Education and Labor, to whom was referred the bill (H.R. 1602) to amend title I of the Employee Retirement Income Security Act of 1974 to provide that such Act does not preempt actions under State law against persons who engage in unfair insurance claims practices, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Health Insurance Claims Fairness Act of 1992".

SEC. 2. IMPROVEMENTS IN CLAIMS PROCEDURE.

(a) CLAIMS REVIEW REQUIREMENTS.—

(1) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended—

(A) by inserting "(a) IN GENERAL.—" after "SEC. 503."; and

(B) by adding at the end the following new subsections:

"(b) CLAIMS REVIEW REQUIREMENTS FOR EMPLOYEE WELFARE BENEFIT PLANS.—An employee welfare benefit plan shall not be treated as complying with the requirements of subsection (a) unless such plan complies with the following requirements:

"(1) TIME LIMIT FOR CONSIDERATION OF COMPLETED CLAIMS.—An employee welfare benefit plan shall provide to any participant or beneficiary claiming bene-

fits under the plan a written notice of the plan's approval or denial of the claim within 30 days after submission of the claim in complete form. In any case in which the claim is denied, the plan shall, within 5 days after the date of the determination to deny the claim, provide the claimant with a written notice setting forth the reasons for the denial, together with notice of the right to appeal the denial under paragraph (2).

"(2) PLAN'S DUTY TO REVIEW DENIALS UPON TIMELY REQUEST.—The plan shall review its denial of the claim if—

"(A) the claimant submits to the plan a written request for reconsideration of the claim after receipt of written notice from the plan of the denial, or

"(B) the claim involves services the aggregate value or expected aggregate value of which is reasonably estimated to exceed $10,000.

The plan shall allow the claimant not less than 60 days, after receipt of written notice from the plan of the denial, to submit the claimant's request for reconsideration of the claim.

"(3) TIME LIMIT FOR REVIEW.—The plan shall complete any review required under paragraph (2), and shall provide written notice of the plan's decision on the claim after reconsideration pursuant to such review—

"(A) before 30 days after receipt of the request for reconsideration, in any case described in paragraph (2)(A), or

"(B) before 30 days after the date of the initial determination, in any case described in paragraph (2)(B).

"(4) DE NOVO REVIEWS.—Any review required under paragraph (2)—

"(A) shall be de novo,

"(B) shall be conducted by an individual who did not make the initial decision denying the claim and who is authorized to approve payment of the claim, and

"(C) shall include review by a qualified physician if the resolution of any issues involved requires medical expertise.

"(c) TREATMENT OF REQUESTS TO GROUP HEALTH PLANS FOR PREAUTHORIZATION.—

"(1) IN GENERAL.—This subsection applies in the case of any request by a participant or beneficiary, or by any person on behalf of a participant or beneficiary, for preauthorization of services which is submitted to a group health plan prior to receipt of such services and which involves—

"(A) urgent treatment for a life-threatening illness, or

"(B) services the aggregate value or expected aggregate value of which is reasonably estimated to total at least $20,000.

"(2) SHORTENED TIME LIMIT FOR CONSIDERATION OF REQUESTS FOR PREAUTHORIZATION.—Notwithstanding subsection (b)(1), a group health plan shall approve or deny any request for preauthorization described in paragraph (1) before 10 days (3 days if the request involves urgent treatment for a life-threatening illness) after submission of the request to the plan.

"(3) AUTOMATIC REVIEW.—The plan shall review any determination to deny a request for preauthorization described in paragraph (1) before 3 days after the date of the initial determination. Any such review shall be conducted in accordance with the requirements of subsection (b)(4) as if the request were a claim to which such subsection applies.

"(4) EXPEDITED EXHAUSTION OF PLAN REMEDIES.—Upon completion of the review required under paragraph (3), the request for preauthorization shall be treated as a claim with respect to which all remedies under the plan provided pursuant to this section are exhausted for purposes of further action under this part.

"(5) DENIAL OF PREVIOUSLY AUTHORIZED CLAIMS NOT PERMITTED.—In any case in which a group health plan approves the request of any person for preauthorization described in paragraph (1)—

"(A) the plan may not subsequently deny any claim by such person for such services, unless the plan makes a showing of intentional misrepresentation by such person of a material fact, and

"(B) if the claim is denied by the plan in violation of subparagraph (A), all remedies under the plan provided pursuant to this section with respect to such claim shall be treated as exhausted for purposes of further action on the claim under this part.

"(d) TIME LIMIT FOR DETERMINATION OF INCOMPLETENESS OF CLAIM.—For purposes of this section, a claim for benefits under an employee welfare benefit plan shall be treated as filed in complete form as of 10 days (3 days in any case in which the claim involves urgent treatment for a life-threatening illness) after the date of the

submission of the claim, unless the plan provides to the claimant, within such period, a written notice of any required matter remaining to be filed in order to complete the claim. Any filing of matter requested by the plan pursuant to this paragraph shall be treated for purposes of this section as an initial filing of the claim.

"(e) ADDITIONAL NOTICE AND DISCLOSURE REQUIREMENTS FOR GROUP HEALTH PLANS.—In the case of a denial of a claim for, or a request for preauthorization of, benefits under a group health plan—

"(1) if the denial is based in whole or in part on a determination that the claim or request exceeds reimbursement rates based on reasonable and customary charges, the notice provided pursuant to subsection (a)(1) shall set forth the factual basis for such determination,

"(2) if the denial is based in whole or in part on exclusion of coverage with respect to services because such services are determined to comprise an experimental treatment or investigatory procedure, such notice shall set forth the medical basis for such determination and a description of the process used in making such determination, and

"(3) if the denial is based in whole or in part on a determination that the treatment is not medically necessary, such notice shall set forth the medical basis for such determination and a description of the process used in making such determination.".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to claims filed after the date of the enactment of this Act.

(b) PROHIBITION OF WAIVER CLAUSES.—

(1) IN GENERAL.—Section 503(a) of such Act (as amended by subsection (a)) is further amended—

(A) by striking "shall";

(B) in paragraph (1), by inserting "shall" after "(1)", and by striking "and" at the end;

(C) in paragraph (2), by inserting "shall" after "(2)", and by striking "claim." and inserting "claim, and"; and

(D) by adding after paragraph (2) the following:

"(3) may not require any party to waive any right under the plan or this Act as a condition for approval of any claim for benefits under the plan, or any request for preauthorization of services under the plan, except to the extent otherwise specified in a formal settlement agreement.

Any waiver described in paragraph (3) shall be null and void unless such waiver is included in a formal settlement agreement.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply with respect to claims filed after the date of the enactment of this Act.

(c) WELFARE BENEFIT CLAIMS ASSISTANCE PROGRAM.—

(1) IN GENERAL.—Section 503 of such Act (as amended by the preceding provisions of this section) is further amended by adding at the end the following new subsection:

"(f) WELFARE BENEFIT CLAIMS ASSISTANCE PROGRAM.—The Secretary shall establish by regulation a welfare benefit claims assistance program. Under the program, the Secretary shall make available to participants and beneficiaries under employee welfare benefit plans ongoing assistance in the resolution of claims under such plans. Such assistance shall include, but not be limited to, reviewing denials of claims, assisting in appeals, contacting employee welfare benefit plans and insurance contractors on behalf of participants and beneficiaries, assisting participants and beneficiaries in obtaining plan documents, and referring of cases for appropriate enforcement action.".

(2) ESTABLISHMENT OF PROGRAM.—The Secretary of Labor shall establish the welfare benefit claims assistance program pursuant to section 503(f) of the Employee Retirement Income Security Act of 1974 not later than 180 days after the date of the enactment of this Act.

(d) TREATMENT OF SETTLEMENT AGREEMENT AS TERMS OF PLAN.—

(1) IN GENERAL.—Section 503(a) of such Act (as amended by subsection (b)) is further amended by adding at the end the following new sentence: "The terms of any settlement agreement entered into under the procedures established by an employee welfare benefit plan pursuant to this subsection shall be enforceable under this title as if such terms were terms of the plan.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to settlement agreements entered into after the date of the enactment of this Act.

(e) DEFINITION OF GROUP HEALTH PLAN.—

(1) IN GENERAL.—Section 3 of such Act (29 U.S.C. 1002) is amended by adding at the end the following new paragraph:

"(42) GROUP HEALTH PLAN.—The term 'group health plan' means an employee welfare benefit plan that provides health care benefits to participants or beneficiaries directly or through insurance, reimbursement, or otherwise.".

(2) CONFORMING AMENDMENT.—Section 607(1) of such Act (29 U.S.C. 1167(1)) is amended to read as follows:

"(1) GROUP HEALTH PLAN.—For the definition of 'group health plan', see section 3(42).".

(f) DEFINITION OF INSURANCE CONTRACTOR.—Section 3 of such Act (29 U.S.C. 1002) (as amended by subsection (e)) is further amended by adding at the end the following new paragraph:

"(43) INSURANCE CONTRACTOR.—

"(A) IN GENERAL.—The term 'insurance contractor' for an employee welfare benefit plan means any insurer who has entered into a legally binding obligation to the plan or plan sponsor to provide benefits under the plan or to administer claims for such benefits.

"(B) INSURER.—For purposes of subparagraph (A), the term 'insurer' means any person or legal entity engaged in the business of insurance, including any insurance company, Lloyds insurer, fraternal benefit society, medical service plan, hospital service plan, health maintenance organization, prepaid limited health care service plan, and dental, optometric, or other similar health service plan. Such term shall include any agent, broker, or adjuster engaged by such a person or entity and any third party administrator engaged to administer benefit claims under an employee welfare benefit plan. For purposes of this title, all entities referred to in this subparagraph which are not employee benefit plans shall be deemed to be engaged in the business of insurance.".

(g) ADDITIONAL DISCLOSURE REQUIREMENTS FOR EMPLOYEE WELFARE BENEFIT PLANS.—

(1) IN GENERAL.—Section 104(b)(4) of such Act (29 U.S.C. 1024(b)(4)) is amended in the first sentence by striking "operated." and inserting "operated, any insurance contract under which benefits are or were provided, and, in the case of a group health plan, any fee or reimbursement schedules for health care providers under the plan.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to requests for any fee or reimbursement schedule which are made after the date of the enactment of this Act.

SEC. 3. EARLY RESOLUTION PROGRAM.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended—

(1) by inserting after the heading for part 5 the following new heading:

"Subpart A—General Provisions";

and

(2) by adding at the end the following new subpart:

"Subpart B—Early Resolution Program

"CHAPTER 1—GENERAL PROVISIONS

"SEC. 521. ESTABLISHMENT OF THE EARLY RESOLUTION PROGRAM; CLAIMS RESOLUTION BOARD.

"(a) ESTABLISHMENT OF PROGRAM.—The Secretary shall establish and maintain an Early Resolution Program for employee welfare benefit plans, which shall be administered in the Department of Labor by a Claims Resolution Board (hereinafter in this subpart referred to as the 'Board').

"(b) IN GENERAL.—The Board shall—

"(1) administer the Early Resolution Program in accordance with regulations of the Board,

"(2) develop Program policy and procedures,

"(3) maintain a roster of arbitrators to act for the Board in arbitration proceedings under chapter 2, and coordinate the recruitment, selection, and training of such arbitrators,

"(4) maintain a roster of facilitators to act for the Board in mediation proceedings between parties conducted under chapter 3, and coordinate the recruitment, selection, and training of such facilitators,

"(5) provide meeting sites, maintain records, and provide arbitrators and facilitators with administrative support staff,

"(6) establish and maintain attorney referral panels, and

"(7) monitor and evaluate the Program on an ongoing basis.

"(c) MEMBERSHIP.—The Board shall consist of qualified attorneys or other professionals appointed by the Secretary who have expertise in the area of welfare benefits. The members shall serve for contemporaneous terms of 3 years and may be reappointed for one additional term. Vacancies for any term shall be filled for the remainder of such term in the same manner as the original appointment. Of the members of the Board—

"(1) 2 members shall represent the interests of employee welfare benefit plans and insurance contractors,

"(2) 2 other members shall represent the interests of plan participants and beneficiaries, and

"(3) the remaining 2 members shall be experienced in mediation, conciliation, and arbitration procedures.

No member of the Board may otherwise serve as an employee of the United States, any State, or any political subdivision of a State. Not more than 3 members shall be of the same political party. Members of the Board shall serve without pay, except that each member shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code. The Board shall elect one member to serve as Chairman.

"(d) EXECUTIVE DIRECTOR AND STAFF.—The Secretary shall provide the Board with such administrative staff and support services as the Secretary considers necessary and appropriate. The administrative staff shall be headed by an Executive Director appointed by the Board. The Executive Director shall serve as the chief executive officer of the Board and in such capacity shall, with the assistance of such staff, conduct case intake under the Program and otherwise assist the Board in carrying out its functions. The Executive Director shall be paid at the rate equivalent to the maximum rate for GS–14 of the General Schedule.

"(e) QUORUM.—Four members of the Board shall constitute a quorum necessary for business, and four affirmative votes shall be necessary for action.

"SEC. 522. ELIGIBILITY OF CASES FOR SUBMISSION TO EARLY RESOLUTION PROGRAM.

"(a) CASE CRITERIA.—A dispute may be submitted to the Early Resolution Program only if the following requirements are met with respect to such dispute:

"(1) PARTIES.—The dispute consists of an assertion by an individual of one or more claims, based on alleged coverage as a participant or beneficiary under an employee welfare benefit plan, against the plan, one or more insurance contractors for such plan, or both, and a denial of such claims, or a denial of appropriate reimbursement based on such claims, by such plan, any such insurance contractor, or both.

"(2) NATURE OF CLAIM.—Each claim consists of—

"(A) a claim for benefits under the plan of the type described in section 3(1); or

"(B) a claim arising out of the failure or refusal by the plan or by an insurance contractor for the plan to comply with the claimant's request for information or documents the disclosure of which is required under this title (including any claim of entitlement to disclosure based on colorable claims to rights to benefits under the plan).

"(3) SUBMISSION AFTER EXHAUSTION OF PLAN REMEDIES AND IN LIEU OF COMMENCEMENT OF CIVIL ACTION.—The claimant has received a final determination regarding the claim under the plan's claims procedure under section 503, or has otherwise exhausted all remedies under the plan provided pursuant to section 503, and no action has been commenced by the claimant under section 502 asserting a claim which is asserted by the claimant in the dispute.

"(b) REPRESENTATION IN CASES OF INCOMPETENCY.—Any claimant who is unable to have a basic understanding of the Program or its process may be represented during the proceedings by a legal guardian or other court-appointed representative.

"(c) NOTICE OF PROGRAM AVAILABILITY.—Each employee welfare benefit plan shall provide, as part of its claims review procedure established pursuant to section 503(a), that claimants taking part in such procedure will be informed during such procedure of the availability of the Early Resolution Program.

"SEC. 523. ARBITRATORS AND FACILITATORS.

"(a) RECRUITMENT.—The Board shall recruit individuals to serve as arbitrators and facilitators under the Early Resolution Program from individuals who have the requisite expertise for such service.

"(b) CRITERIA.—In selecting individuals to serve as arbitrators or facilitators, the Board shall consider the following:

"(1) the individual's experience in dispute resolution.

"(2) the individual's ability to act impartially;

"(3) the individual's ability to perform evaluations quickly and to present them in nontechnical terms; and

"(4) the individual's experience in employee benefit law and, to the extent that the individual's service will relate to group health plans, the individual's expertise pertaining to medical or disability issues;

"(c) TRAINING OF ARBITRATORS AND FACILITATORS.—The Board shall provide a training program for all new arbitrators and facilitators. The curriculum shall include the procedures of the Program, relevant ethical obligations, and skills in arbitration, mediation, and conciliation necessary for effective alternative dispute resolution in the applicable proceedings. An arbitrator or facilitator may serve only upon completion of such training program.

"(d) ASSIGNMENT OF ARBITRATORS AND FACILITATORS TO CASES.—Upon submission of a claim to arbitration proceedings under chapter 2 or mediation proceedings under chapter 3, the Board shall appoint an arbitrator or facilitator (as appropriate) through a random selection procedure which shall be prescribed in regulations of the Board.

"SEC. 524. COMPENSATION OF ARBITRATORS AND FACILITATORS.

"Arbitrators and facilitators serving in the Early Resolution Program may, at their election, serve on a pro bono basis or be compensated at a fixed fee to be established by the Board. The Board shall provide for additional compensation for follow up proceedings. Each arbitrator and facilitator shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

"SEC. 525. ROLE OF ATTORNEYS.

"(a) REPRESENTATION.—Parties may participate pro se or be represented by attorneys throughout the arbitration and mediation proceedings under the Early Resolution Program.

"(b) REFERRALS.—The Board shall maintain attorney referral panels (both fee-paying and pro bono) and referral information regarding other sources of legal assistance. Such panels shall consist of attorneys who are experienced in relevant employee benefit law and willing to represent the parties referred to them.

"SEC. 526. CONFIDENTIALITY.

"(a) ARBITRATORS AND FACILITATORS.—Except as provided in subsections (d) and (e), an arbitrator or facilitator in a proceeding under the Early Resolution Program shall not voluntarily disclose or through discovery or compulsory process be required to disclose any information concerning any proceeding communication or any communication provided in confidence to the arbitrator or facilitator, unless—

"(1) all parties to the proceeding and the arbitrator or facilitator consent in writing, and, if the proceeding communication was provided by a nonparty participant, that the participant also consents in writing,

"(2) the proceeding communication has already been made public,

"(3) the proceeding communication is required by statute to be made public, but an arbitrator or facilitator may make such communication public only if no other person is reasonably available to disclose the communication, or

"(4) a court determines that such testimony or disclosure is necessary to—

"(A) prevent a manifest injustice,

"(B) help establish a violation of law, or

"(C) prevent harm to the public health or safety,

of sufficient magnitude in the particular case to outweigh the integrity of the proceedings in general by reducing the confidence of parties in future cases that their communications will remain confidential.

"(b) PARTIES.—A party to a proceeding under the Early Resolution Program shall not voluntarily disclose or through discovery or compulsory process be required to disclose any information concerning any proceeding communication, unless—

"(1) the communication was prepared by the party seeking disclosure,

"(2) all parties to the proceeding consent in writing,

"(3) the proceeding communication has already been made public,

"(4) the proceeding communication is required by statute to be made public,

"(5) a court determines that such testimony or disclosure is necessary to—

"(A) prevent a manifest injustice,

"(B) help establish a violation of law, or

"(C) prevent harm to the public health or safety,

of sufficient magnitude in the particular case to outweigh the integrity of the proceedings in general by reducing the confidence of parties in future cases that their communications will remain confidential,

"(6) the proceeding communication is relevant to determining the existence or meaning of an agreement or award that resulted from the proceeding or to the enforcement of such an agreement or award, or

"(7) the proceeding communication was provided to or was available to all parties to the proceeding.

"(c) INADMISSIBILITY OF DISCLOSED INFORMATION.—Any proceeding communication that is disclosed in violation of subsection (a) or (b) shall not be admissible in any proceeding relating to the issues in controversy with respect to which the communication was made.

"(d) ALTERNATIVE PROCEDURES.—The parties may agree to alternative confidential procedures for disclosures by an arbitrator or facilitator. Upon such agreement the parties shall inform the arbitrator or facilitator before the commencement of the proceeding of any modifications to the provisions of subsection (a) that will govern the confidentiality of the proceeding. If the parties do not so inform the arbitrator or facilitator, subsection (a) shall apply.

"(e) NOTICE OF DEMANDS FOR DISCLOSURE.—If a demand for disclosure, by way of discovery request or other legal process, is made upon an arbitrator or facilitator regarding a proceeding communication, the arbitrator or facilitator shall make reasonable efforts to notify the parties and any affected nonparty participants of the demand. In any case in which such disclosure would otherwise be in violation of this section, the arbitrator or facilitator may perform such disclosure in accordance with such demand only if each party and affected nonparty participant who receives such notice consents to such disclosure within 15 calendar days after the date of the issuance of such notification.

"(f) EXCEPTIONS.—

"(1) INFORMATION OTHERWISE DISCLOSABLE.—Nothing in this section shall prevent the discovery or admissibility of any evidence that is otherwise discoverable, merely because the evidence was presented in the course of a proceeding under the Early Resolution Program.

"(2) DOCUMENTATION OF AGREEMENTS OR ORDERS.—Subsections (a) and (b) shall have no effect on the information and data that are necessary to document an agreement reached or order issued pursuant to a proceeding under the Early Resolution Program.

"(3) RESEARCH OR EDUCATIONAL PURPOSES.—Subsections (a) and (b) shall not prevent the gathering of information for research or educational purposes so long as the parties and the specific issues in controversy are not identifiable.

"(4) DISPUTES BETWEEN ARBITRATOR OR FACILITATOR AND A PARTY.—Subsections (a) and (b) shall not prevent use of a proceeding communication to resolve a dispute between the arbitrator or facilitator in a proceeding under the Early Resolution Program and a party to or participant in such proceeding, so long as such proceeding communication is disclosed only to the extent necessary to resolve such dispute.

"(g) CIVIL REMEDIES.—

"(1) CIVIL PENALTY.—The Secretary may assess a civil penalty against any person who discloses information in violation of subsection (a) or (b) in the amount of three times the amount of the claim involved.

"(2) DISQUALIFICATION FROM SERVICE.—Any arbitrator or facilitator who discloses information in violation of subsection (a) shall be disqualified from further service as an arbitrator or facilitator under this subpart.

"(h) DEFINITIONS.—For purposes of this section—

"(1) PROCEEDING COMMUNICATION.—The term 'proceeding communication' means any oral or written communication prepared for the purposes of a proceeding under the Early Resolution Program, including any memoranda, notes, or work product of the arbitrator or facilitator, parties, or nonparty participants, except that such term does not include a written agreement to enter into the proceeding or a final written agreement or arbitral award reached as a result of the proceeding.

"(2) IN CONFIDENCE.—The term 'in confidence' means, with respect to information, that the information is provided—

"(A) with the expressed intent of the source that it not be disclosed, or

"(B) under circumstances that would create the reasonable expectation on behalf of the source that the information will not be disclosed.

"CHAPTER 2—ARBITRATION OF DISPUTES

"SEC. 531. ARBITRATION OF CLAIMS DISPUTES.

"Any dispute between a participant or beneficiary and an employee welfare benefit plan, an insurance contractor for such a plan, or both, which is eligible under section 522 for submission to the Early Resolution Program may be resolved through arbitration under this chapter at the election of the claimant. The claimant may initiate the arbitration proceedings under this chapter only by filing with the Board a written election within the 60-day period following (1) the date on which all remedies under section 503 with respect to the claim on which the dispute is based have been exhausted or (2) if mediation proceedings are commenced under chapter 3 with respect to the claim, the date on which such mediation proceedings are terminated without entering into a settlement agreement with respect to the claim.

"SEC. 532. ARBITRATION PROCEDURE.

"(a) IN GENERAL.—An arbitration proceeding under this chapter shall be conducted by arbitrators recruited, trained, and assigned by the Claims Resolution Board under section 523 and in accordance with fair and equitable procedures to be prescribed by the Board which shall be subject to the requirements of this chapter. Any arbitration proceedings under this chapter shall, to the extent consistent with this subpart, be conducted in the same manner, subject to the same limitations, and carried out with the same powers (including subpoena power) as an arbitration proceeding carried out under title 9, United States Code, as if entered into pursuant to agreement by the parties.

"(b) SPECIFIC RULES.—

"(1) NOTICE.—The arbitrator shall set a time and place for the hearing on the dispute and shall notify the parties not less than 5 days before the hearing.

"(2) RECORD.—Any party wishing a record of the hearing shall—

"(A) be responsible for the preparation of such record,

"(B) notify the other parties and the arbitrator of the preparation of such record,

"(C) furnish copies to all identified parties and the arbitrator, and

"(D) pay all costs for such record, unless the parties agree otherwise or the arbitrator determines that the costs should be apportioned.

"(3) PROCEDURE.—

"(A) The parties to the arbitration proceeding are entitled to be heard, to present evidence material to the controversy, and to have such evidence considered on a de novo basis.

"(B) The hearing shall be conducted expeditiously and in an informal manner.

"(C) The arbitrator may receive any oral or documentary evidence, except that irrelevant, immaterial, unduly repetitious, or privileged evidence may be excluded by the arbitrator.

"(D) The arbitrator shall interpret and apply relevant statutory and regulatory requirements and relevant legal precedents and shall ensure that all applicable rights of the parties are protected.

"(c) TREATMENT OF EX-PARTE COMMUNICATIONS.—No party shall make or knowingly cause to be made to the arbitrator an unauthorized ex parte communication relevant to the merits of the proceeding, unless the parties agree otherwise. If a communication is made in violation of this subsection, the arbitrator shall ensure that a memorandum of the communication is prepared and made a part of the record, and that an opportunity for rebuttal is allowed. Upon receipt of a communication made in violation of this subsection, the arbitrator may, to the extent consistent with the interests of justice and the policies underlying this chapter, require the offending party to show cause why the claim of such party should not be resolved against such party as a result of the improper conduct.

"(d) FINDINGS OF FACT BY ARBITRATOR.—There shall be a presumption, rebuttable only by a clear preponderance of the evidence, that the findings of fact made by the arbitrator in the arbitration proceeding were correct.

"(e) ARBITRATOR'S AWARD.—

"(1) ISSUANCE.—The arbitrator shall make the award in an arbitration proceeding under this chapter within 30 days after the close of the hearing, or the date of the filing of any briefs authorized by the arbitrator, whichever date is later, unless the parties agree to some other time limit. The award shall include a brief, informal discussion of the factual and legal basis for the award, but formal findings of fact or conclusions of law shall not be required. The award shall become final 30 days after it is served on all parties.

"(2) AMOUNTS AWARDED.—In any case in which the claimant prevails in the arbitration proceedings, the arbitrator shall award to the claimant the amount of the claim (including reasonable interest) and reasonable attorney's fees and other costs of the proceedings, including reasonable expert witness fees, to be paid by the opposing party or parties, and shall assess all costs of the arbitration, other than costs otherwise provided for under subsection (b)(2), to the other party. Fees awarded under this paragraph shall be at generally prevailing hourly rates. In any case in which the claimant does not prevail, the costs of the arbitration, other than costs otherwise provided for under subsection (b)(2), shall be apportioned among all parties, except that any assessment against the claimant may be waived in whole or in part in the discretion of the arbitrator.

"(3) ADDITIONAL PENALTIES.—

"(A) IN GENERAL.—In any case described in subparagraph (B), an employee welfare benefit plan or insurance contractor which is ordered to pay health benefits required under the terms of the plan as part of an arbitration award issued under this chapter may, in the arbitrator's discretion, be liable to the participant or beneficiary aggrieved by the failure of the plan to pay such benefits, in addition to damages described in subparagraph (A), in an amount not to exceed $10,000 for each instance described in subparagraph (B).

"(B) CASES IN WHICH PENALTIES APPLY.—Subparagraph (A) shall apply in any case in which the arbitrator determines that the liable party—

"(i) caused the exhaustion of remedies under section 503 by means of failing to act on the claim in a timely manner in violation of such section,

"(ii) misrepresented a material plan provision to the participant or beneficiary,

"(iii) refused to pay the claim without conducting a reasonable inquiry in a case where an inquiry is reasonably required,

"(iv) failed to affirm or deny the availability of benefits within a reasonable time after having completed its inquiry related to the claim, or

"(v) attempted to settle the claim, or attempted to compel the participant or beneficiary to institute the action under this section to recover the amount of the claim, by offering to the participant or beneficiary substantially less than the benefit amount ultimately recovered.

"(C) PENALTIES IN ADDITION TO OTHER AMOUNTS AWARDED.—The remedies provided under this paragraph shall be in addition to amounts otherwise awarded under this subsection.

"(4) ENFORCEMENT.—A final award is binding on the parties to the arbitration proceeding, and may be enforced pursuant to sections 9 through 13 of title 9, United States Code.

"(5) PRECEDENTIAL EFFECT OF ARBITRATION AWARDS.—An award entered in an arbitration proceeding under this chapter may not be used as precedent or otherwise be considered in any factually unrelated proceeding, whether conducted under this chapter, by an agency, or in a court, or in any other arbitration proceeding.

"(f) JUDICIAL REVIEW.—Notwithstanding any other provision of law, any person adversely affected or aggrieved by an award made in an arbitration proceeding conducted under this chapter may bring an action for review of such award only pursuant to the provisions of sections 9 through 13 of title 9, United States Code. An appeal may be taken to the appropriate United States court of appeals from an order of a United States district court confirming or denying confirmation of an arbitrator's award made under this subpart or modifying, correcting, or vacating such an award.

"CHAPTER 3—MEDIATION OF DISPUTES

"SEC. 541. INITIATION OF PROCEEDINGS.

"(a) FILING OF ELECTION.—A claimant with a dispute which is eligible under section 522 for submission to the Early Resolution Program and which is not subjected to arbitration pursuant to an election under chapter 2 may elect to participate in such proceedings with respect to such dispute by means of filing with the Board an election for mediation under this chapter. A dispute may be submitted to the mediation proceedings under this chapter only if such dispute consists of an assertion by an individual of one or more claims, based on alleged coverage as a participant or beneficiary under an employee welfare benefit plan, against the plan, an insurance contractor for the plan, or both, and a denial of such claims by the plan or the in-

surance contractor. An election to commence proceedings under this chapter shall be in such form and manner as the Board may prescribe by regulation.

"(b) AGREEMENT TO PARTICIPATE.—

"(1) ELECTION BY CLAIMANTS.—A claimant may elect participation in mediation proceedings under this chapter only by entering into a written agreement (including an agreement to comply with the rules of the Program and consent for the Board to contact the employee welfare benefit plan and any insurance contractor involved regarding the agreement), by releasing plan records to the Program for the exclusive use of the facilitator assigned to the mediation, and by paying to the Board a nonrefundable filing fee of $100. Such fee shall be deposited as miscellaneous receipts in the general fund of the Treasury and is hereby appropriated solely for purposes of administering this chapter. The fee may be waived in cases of hardship, under standards which shall be prescribed by the Board by regulation.

"(2) PARTICIPATION BY PLANS AND INSURANCE CONTRACTORS.—Each party whose participation in the mediation proceedings has been elected by a claimant pursuant to paragraph (1) shall participate in, and cooperate fully, in the proceedings. The Board shall provide each such party with a copy of the participation agreement described in paragraph (1), together with a written description of mediation under the Early Resolution Program. Each such party shall submit such copy of the agreement, together with such party's authorized signature signifying receipt of notice of the agreement, to the Board, shall include in such submission to the Board a copy of the written record of the claims procedure completed by the plan or insurance contractor pursuant to section 503 with respect to the dispute and all relevant plan documents, and shall pay the Board a nonrefundable filing fee of $100. Such fee shall be deposited as miscellaneous receipts in the general fund of the Treasury and is hereby appropriated solely for purposes of administering this chapter. The relevant documents shall include all documents under which the plan is or was administered or operated, including copies of any insurance contracts under which benefits are or were provided and, in the case of a group health plan, any fee or reimbursement schedules for health care providers requested by the facilitator.

"SEC. 542. THE MEDIATION PROCEEDINGS.

"(a) IN GENERAL.—A mediation proceeding under this chapter shall be conducted by facilitators recruited, trained, and assigned by the Board under section 523 and in accordance with fair and equitable procedures to be prescribed by the Board which shall be subject to the requirements of this chapter.

"(b) ANALYSIS STAGE.—In the commencement of the mediation proceedings with respect to any dispute, the facilitator assigned to the dispute shall—

"(1) identify the necessary parties,

"(2) confirm that the case is eligible for mediation under this chapter,

"(3) ensure that each party is informed of available legal representation, including such services as may be available free of charge under legal assistance programs,

"(4) set a conference date,

"(5) at the option of the facilitator, request position papers from the parties of not more than 10 pages in length, if the facilitator determines that such papers are needed to clarify the parties' positions and issues in dispute, and

"(6) analyze the record of the claims procedure conducted pursuant to section 503 and any position papers submitted by the parties, with appropriate legal assistance provided by the Secretary, to determine if further case development is needed to clarify the legal and factual issues in dispute, and whether there is any need for additional information and documents, and request the parties to present any such needed information and documents.

"(c) EVALUATION STAGE.—Upon completion of the procedures described in subsection (b), the mediation proceedings shall proceed as follows:

"(1) COMMENCEMENT OF CONFERENCE.—The facilitator shall convene a conference between the parties. Each party shall be given the opportunity to make a statement summarizing the facts, issues, and arguments in support of such party's position, and present, or inform the facilitator of, any additional evidence such party considers to be relevant to the evaluation.

"(2) NEUTRALITY OF FACILITATOR.—The facilitator shall maintain a neutral stance between the parties.

"(3) PREPARATION OF SETTLEMENT AGREEMENT.—If settlement is reached, the facilitator shall assist in the preparation of a written settlement agreement

(which shall remain confidential at the option of the parties) and shall ensure that the parties understand the terms of the settlement.

"(4) EVALUATION UPON INITIAL FAILURE TO REACH SETTLEMENT.—If no settlement is reached, the facilitator may evaluate for the parties the likely outcome of further administrative action or litigation, based on the facilitator's assessment of the relative strength of each party's position. Any such evaluation by the facilitator shall be treated as a proceeding communication to which section 526 applies.

"(5) FURTHER PROCEEDINGS.—The facilitator shall then encourage extension of the proceedings if it is likely to lead to settlement or a substantial narrowing of the issues.

"SEC. 543. APPLICABLE TIME LIMITS.

"(a) IN GENERAL.—The mediation proceedings under this chapter with respect to any dispute shall be completed within 120 days after the election to participate, as follows:

"(1) PRESENTATION TO PLANS AND INSURANCE CONTRACTORS OF CLAIMANT'S SIGNED AGREEMENT.—The Board shall present to each party whose participation in the mediation proceedings has been elected by the claimant the agreement signed by the claimant within 10 days after the date of the claimant's signature.

"(2) SUBMISSION OF RECEIPT BY PLANS AND INSURANCE CONTRACTORS.—Each party whose participation in the mediation proceedings has been elected by the claimant shall submit within 20 days after receipt of the signed agreement its authorized signature signifying receipt of the notice of the agreement.

"(3) ASSIGNMENT OF FACILITATOR.—The facilitator shall be assigned to the case within 30 days after the date as of which all necessary authorized signatures have been secured.

"(4) COMPLETION OF ANALYSIS STAGE.—The facilitator shall complete all procedures required in the analysis stage described in section 542(a) within 45 days after the facilitator's assignment to the case.

"(5) COMMENCEMENT OF EVALUATION STAGE.—The conference conducted under the evaluation stage described in section 542(b) shall commence not later than the earlier of 60 days after the date of the assignment of the facilitator or 15 days after completion of the analysis stage described in section 542(a).

"(b) EXTENSION OF PROCEEDINGS.—The parties may agree to one extension of the proceedings of not more than 30 days.

"SEC. 544. LEGAL EFFECT OF PARTICIPATION IN PROCEEDINGS.

"(a) PROCESS NONBINDING.—Findings and conclusions made in the mediation proceedings under this chapter shall be treated as advisory in nature and nonbinding. Except as provided in subsection (b), the rights of the parties under subpart A shall not be affected by participation in the mediation proceedings under this chapter.

"(b) RESOLUTION THROUGH SETTLEMENT AGREEMENT.—If a case is settled through participation in the mediation proceedings under this chapter, the facilitator shall assist the parties in drawing up an agreement which shall constitute, upon signature of the parties, a binding contract between the parties, which shall be enforceable under section 546, and which shall be enforceable under this title as if the terms of such agreement were terms of the plan.

"(c) PRESERVATION OF RIGHTS OF NON-PARTIES.—The settlement agreement shall not have the effect of waiving or otherwise affecting any rights to review under section 502 or any other right under this title or the plan with respect to any person who is not a party to the settlement agreement.

"SEC. 545. PROCEDURAL RULES.

"(a) INAPPLICABILITY OF FORMAL RULES OF EVIDENCE.—Formal rules of evidence shall not apply to mediation proceedings under this chapter. All statements made and evidence presented in the proceedings shall be admissible in such proceedings. The facilitator shall be the sole judge of the proper weight to be afforded to each submission.

"(b) INAPPLICABILITY OF OATH REQUIREMENTS.—The parties to the mediation proceedings under this chapter shall not be required to make statements or present evidence under oath.

"SEC. 546. ENFORCEMENT OF SETTLEMENT AGREEMENTS.

"(a) CONFIRMATION; JURISDICTION; PROCEDURE.—At any time within one year after the date of a settlement agreement entered into under this chapter any party to the agreement may apply to the United States district court in and for the district within which such agreement was made for an order confirming the agreement.

Upon such application, the court shall grant such an order unless the agreement is vacated, modified, or corrected as prescribed in subsection (b) or (c). Notice of the application shall be served upon the adverse party. Upon such notice, the court shall have jurisdiction of such adverse party as though such adverse party had appeared generally in the proceeding. If the adverse party is a resident of the district within which the award was made, such service shall be made upon the adverse party or such party's attorney as prescribed by law for service of notice of motion in any action in the same court. If the adverse party is a nonresident, the notice of the application shall be served by the marshal of any district within which the adverse party may be found in like manner as other process of the court.

"(b) VACATION; GROUNDS; REHEARING.—The court may make an order vacating the settlement agreement upon the application of any party to the agreement if—

"(1) the agreement was procured under duress or by corruption, fraud, or undue means, or

"(2) there was evident partiality or corruption in the facilitator who assisted in the making of the agreement.

"(c) MODIFICATION OR CORRECTION; GROUNDS; ORDER.—The court may make an order modifying or correcting the settlement agreement upon the application of any party to the agreement if—

"(1) there was a material miscalculation of figures or a material mistake in the description of any person, thing, or property referred to in the agreement,

"(2) the agreement relates to a matter not submitted in the conference proceedings, unless it is a matter not affecting the merits of the agreement upon the matter submitted, or

"(3) the agreement is imperfect in matter of form not affecting the merits of the controversy.

The order may modify and correct the agreement, so as to effect the intent thereof and promote justice between the parties.

"(d) NOTICE OF MOTIONS TO VACATE OR MODIFY; SERVICE; STAY OF PROCEEDINGS.—Notice of a motion to vacate, modify, or correct a settlement agreement made under this subpart must be served upon the adverse party or the party's attorney within 90 days after the settlement agreement is made. If the adverse party is a resident of the district within which the agreement is made, such service shall be made upon the adverse party or the party's attorney as prescribed by law for service of notice of motion in an action in the same court. If the adverse party is a nonresident, the notice of the application shall be served by the marshal of any district within which the adverse party may be found in like manner as other process of the court. For the purposes of the motion any judge who may make an order to stay the proceedings in an action brought in the same court may make an order, to be served with the notice of motion, staying the proceedings of the adverse party to enforce the agreement.

"(e) PAPERS FILED WITH ORDER ON MOTIONS; JUDGMENT; DOCKETING; FORCE AND EFFECT; ENFORCEMENT.—

"(1) FILING OF PAPERS.—The party moving for an order confirming, modifying, or correcting a settlement agreement made under this chapter shall, at the time such order is filed with the clerk for the entry of judgment thereon, also file the following papers with the clerk:

"(A) the agreement, and

"(B) each notice, affidavit, or other paper used upon an application to confirm, modify, or correct the agreement, and a copy of each order of the court upon such an application.

"(2) DOCKETING OF JUDGMENT.—The judgment shall be docketed as if it were rendered in an action.

"(3) FORCE AND EFFECT; ENFORCEMENT.—The judgment so entered shall have the same force and effect, in all respects, as a judgment in an action, and shall be subject to all the provisions of law relating to such a judgment. Such judgment, including the terms of the agreement (as confirmed, modified, or corrected), may be enforced as if it had been rendered in an action in the court in which it is entered.

"(f) APPEALS.—An appeal may be taken from an order confirming or denying confirmation of a settlement agreement made under this chapter or modifying, correcting, or vacating such an agreement.".

(b) SCOPE OF COURT ENFORCEMENT IN CASES OF ARBITRATION AND MEDIATION.—Section 502(a) of such Act (29 U.S.C. 1132(a)) is amended by adding at the end the following new flush sentences:

"This subsection shall not apply with respect to a claim for benefits under an employee welfare benefit plan with respect to which arbitration proceedings are initiat-

ed under section 531. The applicability of this subsection to any claim shall not be affected by participation in mediation proceedings under chapter 3 of subpart B regarding such claim except to the extent otherwise required under the terms of any settlement agreement entered into in such proceedings.".

(c) MANDATORY COMPLIANCE WITH REQUESTS FOR INFORMATION BY ARBITRATORS AND FACILITATORS IN ARBITRATION OR MEDIATION PROCEEDINGS.—Section 502 of such Act (29 U.S.C. 1132) is amended—

(1) in subsection (a)(5), by striking "or" at the end;

(2) in subsection (a)(6), by striking the period at the end and inserting "; or";

(3) by inserting after subsection (a)(6) the following new paragraph:

"(7) by the Claims Resolution Board to collect any civil penalty under subsection (c)(4).."; and

(4) by inserting at the end of subsection (c) the following new paragraph:

"(4) The Claims Resolution Board may assess a civil penalty against any party to any mediation proceeding under chapter 3 of subpart B of this part of up to $1,000 a day from the date of such party's failure or refusal—

"(A) to supply relevant plan documents or other additional information or documents as requested by the arbitrator in an arbitration proceeding under chapter 2 of subpart B, or

"(B) to supply relevant plan documents as required under section 541(b)(2) or such additional information or documents as are requested by the facilitator pursuant to section 542(b)(6) in a mediation proceeding under chapter 3 of subpart B.".

(d) ENFORCEMENT OF CIVIL REMEDIES FOR VIOLATIONS OF CONFIDENTIALITY.—Section 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

(1) in paragraph (2), by inserting "or section 526(g)(2)" after "section 409"; and

(2) in paragraph (6), by inserting "or section 526(g)(1)" after "(l)".

(e) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended—

(1) by inserting before the item relating to section 501 the following:

"Subpart A—General Provisions";

and

(2) by inserting before the items relating to part 6 the following new items:

"Subpart B—Early Resolution Program

"CHAPTER 1—GENERAL PROVISIONS

"Sec. 521. Establishment of the Early Resolution Program; Claims Resolution Board.
"Sec. 522. Eligibility of cases for submission to Early Resolution Program.
"Sec. 523. Arbitrators and facilitators.
"Sec. 524. Compensation of arbitrators and facilitators.
"Sec. 525. Role of attorneys.
"Sec. 526. Confidentiality.

"CHAPTER 2—ARBITRATION OF DISPUTES

"Sec. 531. Arbitration of claims disputes.
"Sec. 532. Arbitration procedure.

"CHAPTER 3—MEDIATION OF DISPUTES

"Sec. 541. Initiation of proceedings.
"Sec. 542. The mediation proceedings.
"Sec. 543. Applicable time limits.
"Sec. 544. Legal effect of participation in proceedings.
"Sec. 545. Procedural rules.
"Sec. 546. Enforcement of settlement agreements.".

(f) EFFECTIVE DATE AND RELATED RULES.—

(1) IN GENERAL.—The Claims Resolution Board shall issue the initial regulations necessary to carry out the amendments made by this section not later than 1 year after the date on which a quorum of the initial members of the Board are appointed. The amendments made by this section shall take apply with respect to disputes submitted to the Board after such 1-year period.

(2) APPOINTMENT OF INITIAL MEMBERS.—The Secretary of Labor shall appoint the initial members of the Claims Resolution Board not later than 180 days after the date of the enactment of this Act.

(3) TREATMENT OF CERTAIN COLLECTIVELY BARGAINED PLANS.—The amendments made by this section shall not apply with respect to an employee welfare benefit plan if—

(A) such plan is in effect on the date of the enactment of this Act,

(B) such plan is, as of such date, maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and one or more employers, and

(C) the terms of such agreements include, as of such date, and continue to include thereafter, a provision explicitly providing procedures for resolution of claims disputes by arbitration, mediation, or both between participants and beneficiaries and the plan and (if any) insurance contractors for the plan.

SEC. 4. IMPROVEMENTS IN ENFORCEMENT.

(a) RECOVERY OF DAMAGES FOR FAILURE TO PROVIDE BENEFITS AS REQUIRED UNDER AN EMPLOYEE WELFARE BENEFIT PLAN.—

(1) IN GENERAL.—Section 502(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(c)) (as amended by the preceding provisions of this Act) is further amended by adding at the end the following new paragraph:

"(5)(A) In any case in which a claim for a benefit under an employee welfare benefit plan is denied in violation of the terms of the plan or of this title or in which any provision of this title is violated with respect to the administration of the plan in connection with such a claim or the processing of such a claim thereunder, the named fiduciary under the plan and any insurance contractor for the plan administering such claim shall be jointly and severally liable to any participant, beneficiary, employer, employee organization, or plan aggrieved by such failure or violation for actual damages (including compensatory and consequential damages proximately caused by such failure or violation), except that, subject to subparagraph (B), damages for such failure or violation shall not include punitive damages.

"(B) In any case in which a failure or violation described in subparagraph (A) constitutes fraud, each party liable under subparagraph (A) may, in the court's discretion, be liable to the plaintiff for punitive or exemplary damages in addition to damages described in subparagraph (A).

"(C) A named fiduciary under a multiemployer plan shall not be liable under this paragraph.

"(D) The remedies provided under this paragraph shall be in addition to remedies otherwise provided under this section.".

(2) STANDING OF EMPLOYERS, EMPLOYEE ORGANIZATIONS, AND PLANS IN ACTIONS FOR FAILURE TO MEET REQUIREMENTS WITH RESPECT TO BENEFIT CLAIMS.—

(A) IN GENERAL.—Section 502(a) of such Act (29 U.S.C. 1132(a)) (as amended by section 3(c)) is further amended—

(i) in subsection (a)(6), by striking "or" at the end;

(ii) in subsection (a)(7), by striking the period and inserting "; or"; and

(iii) by inserting after subsection (a)(7) the following new paragraph:

"(8) by an employer, an employee organization, or a plan for the relief provided under subsection (c)(5).".

(B) CONFORMING AMENDMENT.—Section 502(e)(1) of such Act (29 U.S.C. 1132(e)(1)) is amended by striking "subsection (a)(1)(B) of this section" each place it appears and inserting "paragraph (1)(A) (with respect to relief under subsection (c)(5)), paragraph (1)(B), or paragraph (7) of subsection (a)".

(b) ACTIONS FOR VIOLATIONS OF STATUTORY REQUIREMENTS.—Section 502(a)(1)(B) of such Act (29 U.S.C. 1132(a)(1)(B)) is amended by inserting "or the provisions of this title" after "plan" each place it appears.

(c) ACTIONS BY PLANS AGAINST FIDUCIARIES.—Section 502(a)(2) of such Act (29 U.S.C. 1132(a)(2)) is amended by striking "beneficiary or fiduciary" and inserting "beneficiary, fiduciary, or plan".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to failures occurring or commencing on or after the date of the enactment of this Act.

SEC. 5. ATTORNEY'S FEES AND COSTS OF ACTION.

(a) IN GENERAL.—Section 502(g) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(g)) is amended—

(1) in paragraph (1), by inserting "or (3)" after "paragraph (2)"; and

(2) by adding at the end the following new paragraph:

"(3) In any action or settlement proceeding under this title with respect to an employee welfare benefit plan by a participant or beneficiary under such plan in which the participant or beneficiary prevails or substantially prevails, the participant or beneficiary shall be entitled to reasonable attorney's fees and other costs of the action, including reasonable expert witness fees, to be paid by the opposing party.

Fees to which the participant or beneficiary is entitled under this paragraph shall be at generally prevailing hourly rates.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to failures occurring or commencing on or after the date of the enactment of this Act.

SEC. 6. CLARIFICATION OF ABILITY OF STATES TO REGULATE THE BUSINESS OF INSURANCE.

(a) IN GENERAL.—Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)) is amended by adding at the end the following new paragraph:

"(9) Subsection (a) shall not apply to any provision of State law to the extent that such provision—

"(A) provides for the establishment or maintenance of any program making available to participants and beneficiaries ongoing assistance in the resolution of claims under group health plans, or

"(B) provides for the licensing or regulation of insurance contractors or provides sanctions against insurance contractors for unfair claims settlement practices.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to violations occurring on or after the date of the enactment of this Act.

SEC. 7. STUDY OF PREEMPTION PROVISIONS.

(a) STUDY.—The Secretary of Labor (or the Secretary's delegate) shall conduct a study on the effects of the provisions of section 514 of the Employee Retirement Income Security Act of 1974 which provide for the preemption of State laws relating to employee benefit plans.

(b) REPORT.—Not later than one year after the date of the enactment of this Act, the Secretary of Labor shall submit to the Committee on Education and Labor of the House of Representatives and the Committee on Labor and Human Resources of the Senate the results of the study conducted under subsection (a), together with any recommendations for legislative reforms which the Secretary finds necessary.

Amend the title so as to read:

A bill to amend title I of the Employee Retirement Income Security Act of 1974 to promote fairness in administration of health insurance and other claims under employee welfare benefit plans and to improve enforcement under such title with respect to such plans.

SUMMARY OF LEGISLATION

H.R. 1602, as ordered reported, amends the Employee Retirement Income Security Act of 1974 (ERISA) in four important respects:

(1) It revises and improves the current claims processing rules applicable to employee welfare benefit plans under section 503 of ERISA by establishing specific statutory time frames for approving or denying claims.

(2) It provides participants and beneficiaries under such plans with faster methods of resolving claims that are still unresolved after all plan appeals have been exhausted by creating statutory options for them to choose mediation or binding arbitration as alternatives to traditional court review.

(3) It revises current Federal remedies under section 502 to assure that actual damages (including any compensatory or consequential damages proximately caused buy the failure to pay claims) will be available in suits against named fiduciaries and insurance contractors (insurers and other third-party administrators) for employee welfare benefit plans. In addition, it requires that reasonable attorneys' fees and other court costs, including expert witness fees, be awarded to prevailing plaintiffs.

(4) As a deterrent to fraudulent behavior, it authorizes a judge to award punitive damages against certain parties under ERISA in suits involving such plans.

Committee Action

On March 22, 1991, Representative Howard L. Berman of California introduced H.R. 1602, which was referred to the Committee on Education and Labor.

On July 18, 1991, the Subcommittee on Labor-Management Relations held a legislative hearing on H.R. 1602 and another preemption bill, H.R. 2782. Testimony on H.R. 1602 was received from Representative Howard L. Berman, the Honorable Masako Dolan, Deputy Commissioner for Policy, Research, and Special Projects, California Department of Insurance, Craig Shapland of California, John M. Morrison of Montana, and James A. Dorsch, Washington Counsel, Health Insurance Association of America.

The Subcommittee met to consider H.R. 1602 on September 25, 1992 and approved the bill without amendment by a 15–7 vote.

H.R. 1602 was considered by the Committee on Education and Labor on July 29 and 30, 1992. Representative Pat Williams, Chairman of the Subcommittee on Labor-Management Relations, offered an amendment in the nature of a substitute from H.R. 1602 as introduced which, by unanimous consent, was considered original text for purposes of amendment.

Representative George Miller offered an amendment to the Williams substitute that established a different model for alternative dispute resolution. For claims with an anticipated aggregate value of $10,000 or less, a dispute could only be resolved through mandatory binding arbitration, rather than traditional court review. With respect to claims involving amounts greater than $10,000, participants would have the option of binding arbitration, mediation or court review. In addition to the value of the participant's claim, reasonable attorneys' fees and other costs, under the Miller amendment an arbitrator would be authorized to award one or more additional $10,000 penalties for each instance in which certain unfair claims practices occurred. The Miller amendment failed by a vote of 14 to 24.

Representative Harris Fawell offered a substitute amendment for the Williams amendment in the nature of a substitute. Under the Fawell substitute amendment, three changes to ERISA were proposed. First, group health plans would be required to provide expedited, full review of requests for preauthorization of claims in which time was of the essence. These claims would include those involving life-threatening illnesses and those in which the cost of services was expected to exceed $50,000. In addition, the Secretary of Labor was directed to review and revise current regulations under section 503 of ERISA and make recommendations to the House and Senate labor committees on legislative changes. Second, the Secretary of Labor was directed to study and make legislative recommendations with respect to alternative dispute resolution procedures. Third, mandatory attorney's fees and costs would be awarded to prevailing plaintiffs in suits for health or disability

benefits. The Fawell substitute amendment failed by a vote of 14 to 25.

Representative Harris Fawell offered an amendment to strike a provision in the William substitute which preserves existing employee welfare plan provisions explicitly providing for procedures for resolution of claims disputes by arbitration, mediation, or both, as long as the provisions were adopted pursuant to a collective bargaining agreement that was in effect on the date of enactment and remain in effect. The Fawell amendment failed by a vote of 15 to 24.

Representative Richard Armey offered an amendment to strike a provision in the Williams substitute relating to the remedies in a legal action available to a participant whose claim is denied under an employee benefit welfare plan. The provision to be struck authorizes the award of actual damages (including compensatory and consequential damages proximately caused by a failure to pay claims) and, in cases of fraud, permits a judge to assess punitive damages. The Armey amendment failed by a vote of 14 to 24.

Representative Harris Fawell offered an amendment to strike a provision in the Williams substitute that exempts named fiduciaries of multiemployer plans from liability for actual or punitive damages under ERISA. Under the Williams substitute, insurance contractors for multiemployer plans would continue to be liable for those damages, but named fiduciaries would not be. The Fawell amendment failed by a vote of 9 to 26.

Representative Richard Armey offered an amendment to prohibit attorneys from receiving contingency fees in connection with legal actions under ERISA involving employee welfare benefit plans. The Armey amendment failed by a vote of 9 to 26.

Representative Harris Fawell offered an amendment to expand the provision in the Williams substitute grandfathering existing employee welfare plan provisions that explicitly provide for procedures for resolution of claims disputes by arbitration, mediation, or both. The Williams substitute preserves those provisions only if they were adopted pursuant to a collective bargaining agreement. The Fawell amendment would have preserved any plan provision establishing claims disputes procedures, regardless of whether the claims dispute procedure was the product of collective bargaining or unilaterally imposed by the employer. The Fawell amendment failed by a vote of 14 to 25.

The Williams amendment in the nature of a substitute was then adopted by a vote of 25 to 15.

On July 30, 1992, the Committee ordered H.R. 1602, as amended, favorably reported by a vote of 24 to 15, a quorum being present.

Background and Need for Legislation

In enacting the Employee Retirement Income Security Act of 1974 (ERISA), Congress established a comprehensive scheme of strong Federal standards to assure that employee benefit plans are established and operated in a fair, secure, and prudent manner and that participants actually receive their promised benefits under the plans. To assure those results, persons who violate ERISA may face both civil enforcement proceedings and criminal prosecution.

Congress wisely did not place the full burden for enforcing ERISA on the three Federal agencies charged with administering the new law (the Departments of Labor and the Treasury and the Pension Benefit Guaranty Corporation (PBGC)). Recognizing the significant new responsibilities that had been conferred on these agencies and the substantial resources that would be necessary to discharge those responsibilities, Congress established an enforcement structure that relied on Executive Branch oversight and litigation, buttressed in the areas of fiduciary violations and benefit claims disputes by private rights of action.

In the eighteen years since ERISA was enacted, it has become apparent that enforcement of the Act's major provisions has been uneven at best. While the Department of the Treasury and the Internal Revenue Service have focused on the rules contained in the Internal Revenue Code, the PBGC on pension plan terminations under Title IV, and the Department of Labor on Title I reporting, disclosure, and fiduciary issues, workers and retirees whose benefit claims have been denied or mishandled have been basically on their own.

The ERISA agencies have not undertaken to assist participants in any meaningful way to assure that their claims are paid. See generally, "Are Your Pension Rights Protected? Hearings before the Subcommittee on Retirement Income and Employment of the House Select Comm. on Aging," 102nd Cong. 2nd Sess. 102–854 (1992). In part, this is because these agencies believe they have no legal obligation to assist participants. See, e.g., Id. at 231 (citing Frank Greve, "Heat is on U.S. Pension Watchdog," Philadelphia Inquirer, Feb. 2, 1992, C–1). In part this is a function of the limited resources available to the agencies and the relatively low priority this function has been assigned within the agencies. Recent efforts in the Department of Labor to develop a more formal program of participant assistance are a welcome, albeit small, first step in the right direction.

Thus faced with no viable alternative, workers and retirees have increasingly turned to the courts in growing numbers as they encounter problems with their employee benefit plans. Although initially most ERISA litigation involved pension claims, as medical costs continue to skyrocket, more and more disputes have arisen involving health and disability benefits.

In the early 1980s, the Subcommittee on Labor-Management Relations became aware that in certain states (primarily California, Texas, Illinois, Florida, and New York), a substantial increase in the number of denials by insurers of medical and disability claims under ERISA welfare plans was becoming a problem. Generally, the participants involved were AIDS patients. Inquiries about ERISA and its impact on state laws governing insurance company behavior in connection with ERISA-covered health and disability plans began to be received with far more frequency from members of Congress, state insurance officials, attorneys for these patients, and members of the patients' families. Because ERISA itself provides very few substantive rules for welfare plans, aggrieved participants have relied primarily on state unfair claims practice laws to protect them and provide meaningful remedies to deter against insurance company abuse.

A. PILOT LIFE

On April 6, 1987, in *Pilot Life Insurance Co.* v. *Dedeaux,* 481 U.S. 41 (1987), the Supreme Court nullified the application of state laws governing unfair claims practices laws to ERISA plans and, in so doing, severely weakened the ability of participants to enforce their rights.

In *Pilot Life,* the court held that Mississippi common law tort and contract law providing remedies for improper processing of a claim for benefits under an insured long-term disability plan was preempted by ERISA, since it was a law of general application relating to an employee benefit plan and not a law regulating insurance. The case involved an employee of Entex, Inc., Everate W. Dedeaux, who was covered under a long-term disability plan insured by the Pilot Life Insurance Company. Although found to be permanently disabled in 1975, Dedeaux's benefits were abruptly terminated after two years. During the following three years, his benefits were reinstated and terminated by Pilot Life several times. Finally Dedeaux sued Pilot Life under Mississippi common law for "tortious breach of contract," "breach of fiduciary duties," and "fraud in the inducement" for its failure to pay benefits under the ERISA-covered plan. The United States Court for the Southern District of Mississippi granted the company's motion for summary judgment, holding the claims preempted by ERISA. On appeal, the United States Court of Appeals for the Fifth Circuit reversed and reinstated the suit. The Supreme Court agreed with the district court, reversed the decision of the Fifth Circuit, and held Mr. Dedeaux's claims preempted.

In reaching that result, the Court concluded that Mississippi's common law causes of action (including those for tortious breach of contract and bad faith) "related to" an employee benefit plan and did not fall within the "insurance" law exception.

Section 514(a) of ERISA contains sweeping language stating that "the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan * * * ." Subsection (b) (the so-called "savings clause"), however, contains several specific exemptions from the broad preemption provided for in subsection (a), including exemptions found in section 514(b)(2)(A) for "any law of any State which regulates insurance, banking, or securities." Under section 514(c)(1) of ERISA, the term "state law" includes all laws, decisions, rules, regulations or other State action having the effect of law. Finally, section 514(b)(2)(B) makes it clear that states cannot evade ERISA's preemptive effect by deeming employee benefit plans to be insurance companies or entities engaged in the business of insurance.

In analyzing Mississippi law in relation to ERISA's savings clause, the Court focused on whether the state common law of bad faith was a State law regulating insurance. To conclude it was not, the court looked to its previous opinion in *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724 (1985), and determined that the practice at issue (bad faith actions by an insurance company in connection with claims payments) was not part of the "business of insurance" for purposes of the McCarran-Ferguson Act. The basis for that determination was the application of a three-part test, de-

veloped by the Supreme Court through cases interpreting McCarran-Ferguson. Under those precedents, to determine whether a particular practice constitutes the "business of insurance", one must evaluate: 1) whether the practice has the effect of transferring or spreading a policyholder's risk, 2) whether the practice is an integral part of the policy relationship between the insurer and the insured, and 3) whether the practice is limited to entities within the insurance industry. *Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119, 129 (1982). The court concluded that, at most, the Mississippi law of bad faith at issue in *Pilot Life* met only the second criterion described above. Thus the court concluded that the state law was preempted by ERISA.

Moreover, in response to an argument made by the Solicitor General of the United States, as amicus curiae, the court also ruled that the civil enforcement provisions of ERISA in section 502(a) were the "exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits * * * ." This conclusion was based largely on the court's analysis of legislative intent and the fact that ERISA's enforcement provisions were modeled on section 301 of the Labor-Management Relations Act.

In its discussion of the exclusivity of the ERISA remedies, the Court strongly implied that the punitive damage remedy provided under Mississippi bad faith law was not available under ERISA. But because the plaintiff did not assert a cause of action under ERISA, the Court did not examine whether any of the relief sought by Mr. Dedeaux was actually included in ERISA's current remedies.

Although the Court's initial conclusion that Mississippi law was preempted was not surprising to most experts, its decision to exclude remedies from Congress' clear and broad direction to the federal courts to create a federal common law of ERISA was both surprising and troubling.

In large part, the Committee's support for legislation related to unfair claims practices reflects its concern that the current remedies under ERISA are inadequate to assure that participants' rights are fully protected when it comes to payments of medical claims. The Committee's concern is heightened because most courts have narrowly construed both the types of causes of action which may be brought and the remedies available under ERISA.

B. ERISA REMEDIES

The causes of action in civil proceedings under ERISA are listed in section 502(a) of the Act. They include the following:

1. A participant or beneficiary may bring suit under:

   Section 502(a)(1)(A) for the relief provided in section 502(c) ($100 per day penalty for failure to provide required information), or

   Section 502(a)(1)(B) to recover benefits due under the terms of the plan, to enforce rights under the terms of the plan, or to clarify rights to future benefits under terms of the plan.

2. The Secretary of Labor, a participant, beneficiary, or fiduciary may bring suit under section 502(a)(2) for appropriate relief under

section 409 (personal liability to make good for any losses caused by the plan as a result of a fiduciary breach).

3. A participant, beneficiary, or fiduciary may bring suit under:

Section 502(a)(3)(A) to enjoin any act or practice which violates any provision of Title I of ERISA or of the plan, or

Section 502(a)(3)(B) to obtain other equitable relief to redress such violation or enforce any provision of Title I or of the plan.

4. The Secretary, a participant, or beneficiary may bring suit under section 502(a)(4) for appropriate relief for violations of section 105(c) (relating to individual benefit statements).

5. Under certain conditions, the Secretary of Labor may bring a civil action under section 502(a)(5) to enjoin any act or practice which violates any provision of Title I or to obtain other appropriate equitable relief to redress such violation or to enforce any provision of Title I.

6. The Secretary of Labor may bring a civil action under section 502(a)(6) to collect any civil penalty due under section 502(i) (relating to prohibited transactions) or section 502(l) (relating to an additional 20% penalty on certain violations).

In addition, a plan administrator, fiduciary, participant, or beneficiary may bring a civil action against the Secretary of Labor for judicial review of actions or inaction by the Secretary. The Secretary is also authorized to intervene in any private lawsuit brought under section 502(a).

The courts have been very careful to distinguish between cases based on the particular paragraph of section 502(a) under which the case is brought. These distinctions determine both who may properly bring a suit and what relief is authorized.

Pilot Life has been broadly interpreted by some commentators to preclude not only state remedies for unfair claims practices, but also any recovery under ERISA other than the value of the original claim. The Supreme Court itself, however, has not definitively addressed the question as to what extent participants and beneficiaries may obtain damages under section 502(a)(3) of ERISA resulting from the plan's refusal to pay benefits. But the Court has ruled out certain damages with respect to other paragraphs of section 502(a).

In *Massachusetts Mutual Life Ins. Co.* v. *Russell*, 473 U.S. 134 (1985), the Supreme Court decided that a fiduciary with respect to an employee benefit plan could not be held liable to a participant under section 409(a) of ERISA for extracontractual compensatory or punitive damages caused by improper or untimely processing of benefit claims. *Russell* was a suit brought under both state law and section 502(a)(2) of ERISA. After holding the state law claims preempted by ERISA, the Court denied relief to the plaintiff under ERISA. In reaching its decision, the Court concluded that ERISA expressly authorized equitable or remedial relief under section 409(a) only for the benefit of the plan and not for the benefit of an individual. The court also expressly declined to find an implied right of action for an individual that would result in such relief under section 502(a)(2).

In his concurring opinion in *Russell*, however, Justice Brennan pointed out that since section 502(a)(3) already authorizes "other appropriate equitable relief", there was no reason for the court to

stretch its interpretation of section 409 to include it. 473 U.S. 155–58 (Brennan, J., concurring). The clear implication is that the door may not be entirely closed on extracontractual damages for participants whose benefit claims have been improperly handled or erroneously denied.

More recently, Justice O'Connor provided an additional hint that extracontractual damages might be available under appropriate circumstances. Writing on behalf of a unanimous Court in *Ingersoll-Rand Co.* v. *McClendon*, 111 S.Ct. 478 (1990), Justice O'Connor noted in dicta that the type of damages being sought under the state common law wrongful discharge claim were "well within the power of federal courts to provide", although the state claims at issue were preempted by ERISA. 111 S.Ct. at 486.

The committee is encouraged that these signs may indicate the Supreme Court will conclude that participants whose claims for benefits have been denied and who seek "other appropriate equitable relief" under section 502(a)(3) are entitled to recover at least actual damages, and not merely the contract value of their original claim. The Committee believes that the recovery of amounts designed to make a participant whole is within the present ambit of section 502(a)(3).

C. PARTICIPANT PROTECTIONS AFTER PILOT LIFE

In addition to the Committee's concern that the scope of ERISA's current remedies may have been too narrowly interpreted by some courts, there is also concern that these remedies may in fact be inadequate to assure that participants whose claims for benefits are improperly handled or unfairly denied have adequate means to ensure compliance with the Act or the terms of their plan.

The Committee first addressed these concerns in connection with the *Pilot Life* case in 1989 in a report accompanying H.R. 3299, the Omnibus Budget Reconciliation Act of 1989 (H.Rept. 101–247 101st Cong. 1st sess.) as follows:

> In recent years, the Committee has received numerous complaints and inquiries from Members of Congress and their constituents about improper denials of medical claims, improper denials of continuation coverage, or unreasonable delays in processing claims by employers or insurers. Participants in ERISA-covered employee benefit plans that have been treated in this manner are concerned that the Supreme Court's interpretation of ERISA (particularly as articulated in *Pilot Life Insurance Co.* v. *Dedeaux*, 107 S.Ct. 1549 (1987)) as preempting state laws that authorize punitive or other extracontractual damages in connection with claims for benefits effectively denies them of legal recourse. The Committee shares their concern. In *Pilot Life*, the Supreme Court held that state common law claims against an insurance company for breach of contract and bad faith arising out of an improper denial of disability benefit claims under an ERISA-covered plan were preempted. In addition, the Supreme Court declined to fashion a Federal common law remedy for improper processing of benefit claims, holding that ERISA's civil en-

> forcement provisions under section 502 were intended to be the exclusive remedies afforded to plan participants and beneficiaries. The Committee disagrees with this latter conclusion. The Committee believes that the legislative history of ERISA and subsequent expansions of ERISA support the view that Congress intended for the courts to develop a Federal common law with respect to employee benefit plans, including the development of appropriate remedies, even if they are not specifically enumerated in section 502 of ERISA. Since the issue of preemption is within the exclusive purview of the labor committees of Congress, the Committee has, over the years considered the option of amending the statute to encompass specifically several additional remedies. In light of the legislative history on this issue, however, the Committee believes that such action is unnecessary. The Committee reaffirms the authority of the Federal courts to shape legal and equitable remedies to fit the facts and circumstances of the cases before them, even though those remedies may not be specifically mentioned in ERISA itself. In cases in which, for instance, facts and circumstances show that the processing of legitimate benefit claims has been unreasonably delayed or totally disregarded by an insurer, an employer, a plan administrator, or a plan, the Committee intends the Federal courts to develop a Federal common law of remedies, drawing upon principles enunciated in state law, including such remedies as the awarding of punitive and/or compensatory damages against the person responsible for the failure to pay claims in a timely manner.

H. Rept. 101–247 at pp. 55–56.

Since the Committee first expressed those views in 1989, few courts have followed this directive. In reality, little progress has been made to assure that participants and beneficiaries have effective or adequate recourse to the courts when the medical claims are not paid. As a result, the only legal remedies participants have are those provided by ERISA. Unfortunately, until the Supreme Court rules otherwise, most courts have taken the narrow view and concluded that if a person's benefit has been erroneously denied, payment of the original claim amount is sufficient. In addition, in the court's discretion, attorney's fees may be awarded.

Since *Pilot Life* was decided, the number of complaints about insurance company behavior has mushroomed. Currently little financial downside exists for an insurance company that routinely delays payment or refuses to pay large claims.

The offending insurance company probably won't lose the employer's business. It is so difficult for employers (particularly small businesses) to find insurance coverage at all, that they are unlikely to change carriers just because claims payments for one or a few of their employees are delayed or rejected. Moreover, since litigation is costly and time-consuming, most employees are unlikely to sue over a rejected claim, even if it is in the $10,000 to $30,000 range. Finally, even if a suit is brought and the court finds that the insurance company has behaved in the most egregious and outrageous

way, the worst that could happen to the insurance company is that it would be forced to pay the claim it should have paid in the first place.

Although insurers argue that they are in the business of paying claims, not denying them, and that companies with poor claims paying records will lose clients, that argument assumes that a disgruntled employer has some leverage over the insurer. Rarely is that the case. Most employers large enough to have clout with an insurer would probably decide to self-insure. Small or medium-sized businesses are far less likely to be able to convince an insurer that a particular claim ought to be paid, especially if the claim in dispute is large or involves treatment or procedures that are not universally accepted. Changing carriers if the claims decision is not reversed is simply not a viable option in most cases. Consequently, some employers have registered their concerns by joining participants in their suits against insurers.

D. DEVELOPMENT OF A LEGISLATIVE PROPOSAL

In light of these concerns, Representative Howard Berman introduced H.R. 1602 on March 22, 1991. As originally introduced, H.R. 1602 amended ERISA to reinstate state unfair claims practices laws which were nullified by the Supreme Court in 1987 in the *Pilot Life* decision. In effect, it restored to the states the right to prescribe remedies against insurance companies and other insurers in suits brought by individuals covered under ERISA-covered group health plans. Many of these state laws currently authorize the recovery of punitive and other extracontractual damages, including compensation for pain and suffering.

Representative Berman's approach was simple: put things back the way they were prior to the Supreme Court's decision. Prior to that time, insurers were required to comply with various state laws in the administration of their group insurance contracts. To return to the pre-1987 situation would not, therefore, impose any undue hardship or new requirements on insurers. In addition, this approach would be consist with the traditional view that regulation of the business of insurance was a state, not a Federal responsibility.

Nevertheless, restoration of state laws strongly opposed by the insurance industry and others who believed that restoring state unfair claims practices laws was an unwise course and would conflict with ERISA's goal of providing a uniform regulatory structure for all plans. In addition, they argued that current ERISA remedies were sufficient to deal with any problems that might occur with respect to disputed claims. Moreover, they insisted that it was appropriate to limit a participant's recovery to the value of the original claims, regardless of whether the insurer had been grossly negligent or willful in denying the claim and regardless of the damage that the participant had suffered as a result of the claim denial.

Although, on a bipartisan basis, most members of the Committee believed that the current situation needs to be changed, there was no agreement about what to do. One thing was clear, however, little support existed for restoring state remedies. Representative Pat Williams, the Chairman of the Subcommittee on Labor-Man-

agement Relations, to which H.R. 1602 was referred, sought to bring the opposing sides together to develop a compromise that provided for federal remedies in ERISA, rather than restoring state law.

For over a year, Chairman Williams urged the insurance industry and others who opposed the bill to work with him to fashion compromise legislation that was more acceptable. However, the insurance industry and the business community generally continued to oppose the bill strongly.

While opposing any change in damages under ERIS, Blue Cross and Blue Shield proposed consideration of several improvements in current claim handling practices, including the adoption of an expedited procedure for claims involving life-threatening illnesses or amounts over $50,000, and study of alternative dispute resolution mechanisms to reduce litigation over medical claims. The mandatory award of attorney's fees to prevailing plaintiffs in court was also proposed as a way of removing one of the current barriers to adequate legal representation for plaintiffs.

As the discussion of claims disputes problems evolved, several other issues emerged. Among them were the need for a faster, more affordable alternative to court review and the concern that any new procedures or remedies incorporated into ERISA be applicable not only to insurance companies but to all employee welfare benefit plans.

Most members agreed that both participants and employers could benefit if procedures could be developed that would create incentives to settle claims disputes without going to court. After research and discussion with experts in dispute resolution techniques, a mediation and conciliation proposal was developed, based on a model for an early resolution program for pension claims which had been developed under a grant from the National Institute for Dispute Resolution by the Pension Rights Center.

Some believed that an adjudicatory model was more appropriate. Representative George Miller developed an alternative approach along those lines. Based on the assumptions that more than 90 percent of claims are less than $10,000 and that individuals with small claims are unlikely to be able to find adequate legal representation to pursue their claims in court, a two-track approach was developed. Under the Miller model, claims disputes involving amounts under $10,000 would have had to be resolved through binding arbitration, rather than court review. With respect to claims involving amounts greater than $10,000, participants could choose either binding arbitration, mediation or court review.

A final concern expressed was the need to broaden the scope of any ERISA changes to cover all plans, not just insurance companies or other insurers. Although this approach was supported in principle, fiduciary insurance difficulties arose in applying new remedies to the trustees of multiemployer plans.

Eventually, a substitute for the original bill was offered when the full committee considered H.R. 1602. The substitute responded to the concerns expressed by the Administration, the insurance industry, the business community, and Committee Republicans about inconsistent state regulation and the need for uniformity by estab-

lishing a Federal ERISA standard for claims processing for all plans.

To address the threshold problem of lack of timely response to claims, the Committee bill amends ERISA to require that claims be approved or denied within 30 days and that appeals be decided within 30 days. In addition, a special expedited claims procedure for urgent treatment involving life-threatening illnesses is established.

To assure faster resolution of claims disputes, the bill establishes an alternative dispute resolution program giving participants the choice between an expedited mediation process and binding arbitration as an alternative to court review. In effect, participants could choose between mediation, arbitration, and court review. If the participant chooses mediation and the mediation results in a settlement, parties are bound and the agreement is enforceable in court. If no agreement is reached, the participant can either choose binding arbitration or go to court. If the participant chooses arbitration and prevails, an arbitrator may award to a participant (in addition to the claim amount and attorney's fees) one or more additional $10,000 penalties if certain conditions are met.

To remedy the problems caused by the *Pilot Life* decision, participants who successfully challenge claims denials can recover additional damages designed to make them whole for losses they suffer when their claims are unfairly denied (compensatory and consequential damages). In cases of fraud, punitive damages are also available but may be awarded by a judge, not a jury. Reasonable attorney's fees must be awarded to successful plaintiffs.

Generally named fiduciaries and insurance contractors (insurance companies and others who are contractually obligated to administer claims) are jointly liable for any compensatory, consequential, and punitive damages that may be awarded. In the case of multiemployer plans, however, only insurance contractors and not individual trustees are liable for these damages.

The provisions of the substitute adopted by the Committee represent a compromise approach to a number of difficult problems. As the debate within the Committee illustrated, although a majority of members believe that change is necessary and support the substitute, they remain open to other approaches to solve the problems.

Committee Views

The Committee believes that ERISA does not provide sufficient protections to participants and beneficiaries to assure that their claims for benefits are handled in a timely, efficient, and fair manner. In addition, the Committee is concerned that current court interpretations of ERISA have removed disincentives to unfair claims practices and have weakened the ability of participants to enforce their rights under ERISA. As a result, the balance struck in ERISA between the competing interests of plan sponsors and participants has been upset.

For these reasons, the amendments to ERISA incorporated in H.R. 1602, as reported, are necessary to reinforce what the framers of ERISA believed they were doing in 1974: protecting participants

and beneficiaries by assuring that their benefit claims are properly handled and providing a meaningful enforcement mechanism and remedies when they are not.

It has become painfully obvious in reviewing recent court decisions relating to benefit claims that many courts have interpreted ERISA as a shield to insulate insurers, plans and employers, from covering and paying legitimate claims of participants, rather than interpreting ERISA as it was intended: a shield for participants to protect against unfair treatment in connection with their benefits. These recent interpretations of ERISA turn the statute on its head.

One troubling recent example of this problem is a case involving a Louisiana wrongful death action brought by a plan beneficiary alleging that an unborn child died as a result of various acts of negligence committed by the insurance contractors, including medical malpractice by a reviewing physician. The court found that the state claims were preempted by ERISA, and, at the same time, denied relief under ERISA. *Corcoran* v. *United Health Care, Inc., and Blue Cross and Blue Shield of Alabama, Inc.,* 965 F.2d 1321 (5th Cir. 1992).

Although ERISA may have been intended to be a comprehensive Federal approach to employee benefits, in practice, ERISA has proved deficient in assuring the protection it promised. This is particularly true in the area of claims disputes.

Participants are often at a serious disadvantage when they question claims decisions. On their own, such participants must navigate the murky, frightening and often treacherous waters of the plan's claims procedures, usually without either an up-to-date navigational chart or an experienced guide. In contrast, employers, plans, and insurance contractors have many advantages: first, they make the initial design choices and have the ongoing ability to alter the plan; second, they create the bureaucracy to administer the plan and therefore understand how to make the bureaucracy work for them; and third, they are supported by a well-paid flotilla of service providers and advisors.

In most instances, this "David and Goliath" situation is not necessarily harmful to participants, since most legitimate claims are ultimately paid. But sometimes the lag time between the filing of the claim and its payment is substantial. And often the claim is rejected several times before it's paid, either because more information is needed or because the previously requested information which had been provided by the claimant has somehow not made its way to the appropriate claims person. And sometimes a claim that should be paid is simply ignored or denied through gross negligence or deliberate action.

The Committee believes that ERISA does not currently assure that covered claims be paid in a timely fashion. Moreover, the lack of effective remedies for unfair claims practices means that ERISA does not provide the strong deterrence necessary to assure that claims are not denied because of gross negligence or willfull actions.

Although many of the committee's concerns are equally applicable to pension claims, H.R. 1602 only tackles the problems associated with claims under employee welfare benefit plans.

First, H.R. 1602 establishes statutory time limits for the initial approval or denial of a claim, the appeal of claims denials, and the review of denied claims. These time limits are somewhat shorter than are currently permitted under the regulations promulgated by the Department of Labor but longer than most states require under their unfair claims practices laws and longer than the National Association of Insurance Commissioners recommend in their model statute. The Committee attempted to strike a balance between the need to resolve claims issues in a timely manner and the burdens on the insurance contractor or plan making the claim decision.

In addition, the Committee recognized that certain types of claims require a more rapid decision than the general rules would require. Adopting the suggestion of Blue Cross Blue Shield, a shorter period is provided when requests for preauthorization of urgent treatment for life-threatening illnesses are involved. The decision as to whether a particular claim ought to be eligible for expedited treatment should be based on patient need as determined in consultation with a treating physician, and must be an ongoing process. The decision as to whether treatment is "urgent" or whether it involves a "life-threatening illness" cannot be based solely on an arbitrary review of medical records and a predetermined list of conditions that will or will not be characterized as "life threatening".

Similar rules for expedited treatment are provided if the aggregate value of the necessary services totals at least $20,000. The Committee intends that these requests for treatment include both requests for a particular covered service or procedure (e.g., heart transplant) as well as a potential course of treatment (e.g., one year of radiation therapy for cancer).

Another major concern of the Committee is the need to provide a faster, less expensive alternative to court review for disputes that still exist after all claims review procedures under the plan are exhausted.

Most claims disputes are based on simple misunderstandings, miscommunications, or distrust that the process for deciding claims has been fair. Most of the disputes that involve the first two of these factors are likely to be resolved within the plan's internal claims review process. Particular distrust of the fairness of the claims procedure seems to arise when the person making the claims decision has a direct or indirect financial stake in denying the claim. If a participant believes that the decision to deny a claim is motivated by a desire to save money, he or she may be more likely to challenge the denial.

Yet employers are struggling to cope with ever-increasing costs of providing health care and cannot be expected simply to approve all claims that are submitted, regardless of their merit. Ironically, the growing movement among employers to control costs by demanding greater accountability from and providing greater oversight over providers and expenditures through the establishment of provider networks, often brings with it heightened concerns by participants that needed care might be arbitrarily denied. H.R. 1602 as reported tries to strike a balance. It does not disrupt well-designed and legitimate managed care arrangements, but it will provide a

mechanism to require accountability for those insurance contractors and plans who would substitute arbitrary claims denials for genuine cost-containment.

H.R. 1602 establishes an early dispute resolution program so that many of the cases which today wind up in court might be more easily settled without resorting to litigation. Litigation is an expensive, time-consuming and often frustrating way to resolve disputes. Substantial barriers exist for participants in securing competent and reasonably priced legal assistance. Employers and plans would also benefit from avoiding litigation. Thus an early dispute resolution program holds the promise of substantial improvement over the current situation for both employers and participants.

The Committee initially considered providing only a mediation and conciliation alternative to court review. Mediation is particularly suited to welfare benefit claims, since it is a non-threatening, informal method of having an impartial expert examine the facts, secure the relevant plan documents, evaluate the relative strengths and weaknesses of the arguments on both sides of the dispute, and, based on that evaluation, assist the parties to work through their differences and settle their dispute. Experts in dispute resolution believe that mediation is the best alternative in situations in which a relationship between the parties will continue even after the dispute is settled. Because the process is voluntary on the part of the participant, informal, nonadversarial, and no decision is imposed on the parties, it allows the parties to reach an agreement without jeopardizing their continuing relationship.

When some members of the Committee suggested that arbitration was more appropriate in order to assure that the resolution of the dispute occurs quickly and with finality, the committee began to examine arbitration models in more detail.

Generally arbitration is used when little likelihood exists that a negotiated settlement can be reached and where no continuing relationship between the parties will exist after the dispute is resolved. Some experts advised against the use of arbitration in benefit claims disputes because of the clearly unequal bargaining positions of the parties. In effect, the arbitration process pits consumers against well-financed, well-represented institutional interests who will quickly develop a mastery of the process since they will have many pending claims disputes working their way through the system. On the other hand, arbitration could be very useful to those participants who would simply like a decision, one way or the other, as quickly as possible.

The Committee's evaluation of these options was somewhat complicated by a proposal advocated by Representative George Miller. The Miller proposal would provide participants with a choice of alternative dispute resolution options for claims with a value greater than $10,000, but would require all claims below that amount to be resolved through mandatory binding arbitration. Even among those who believed binding arbitration was a good idea, concerns were raised about a mandatory binding arbitration procedure. Since ERISA currently provides a statutory right which cannot be waived to pursue judicial resolution of benefit claims disputes, the committee was reluctant to take away this valuable right. In addition, to move from the current system of judicial review with the

full range of Constitutional protections to a new mandatory binding arbitration program for all claims below $10,000 was a big step, particularly since little objective analysis had been done of the efficacy of the few binding arbitration programs that are currently in operation. When arbitration proceedings take on the legal trappings of the courts, they can turn out to be neither less expensive nor quicker than the courts for participants.

In the end, the Committee adopted a compromise approach in H.R. 1602 as reported. Participants may choose among three options: mediation, arbitration, or court review. The insurance contractor, plan, or employer is obligated to participate in whatever process the participant chooses.

If mediation is selected, but no settlement is reached, the participant may then elect binding arbitration or court review. However, once the participant has arbitrated the dispute, he or she is barred from later pursuing a resolution in court. This approach achieves the objective of finality: the claim cannot be heard in another forum. However, this also means that it is essential for a participant to understand the full legal effect of choosing binding arbitration. The Committee expects that, as part of the written election to participate, the participant will be given a simple-to-understand explanation of the consequences of choosing arbitration.

In both types of adjudicatory proceedings (binding arbitration and civil litigation), the Committee intends the benefit claim denial to be reviewed de novo. In other words, the committee intends that the parties have the right to submit new evidence and that no deference be given to the factual findings and interpretations of plan terms by the decisionmaker below. Limiting the evidence to what was available to the plan administrator severely penalizes the participant who does not want or cannot afford to hire a lawyer to identify and obtain all relevant evidence during the earlier stages of review, and the Committee disagrees with decisions that limit de novo review to the record below. See, e.g., *Perry* v. *Simplicity Engineering,* 900 F.2d 963 (6th Cir. 1990).

The Committee believes that whenever the decisionmaker has not been given discretion to interpret the terms of a plan or when the decisionmaker has any financial stake in the decision (regardless of whether such discretion has been authorized), current law requires such de novo review. *Firestone Tire & Rubber Co.* v. *Bruch,* 489 U.S. 101 (1989).

If the participant decides to litigate the claim, the full range of legal and equitable remedies are available to successful plaintiffs. As previously discussed, the Committee believes that section 502(a)(3)(B) of ERISA already authorizes courts to award actual damages designed to make the aggrieved individual whole when either the terms of the plan or the Act have been violated. In that respect, H.R. 1602 merely clarifies current law with respect to the remedies available for benefit claims.

In addition, H.R. 1602 responds to the potential vacuum that may have been created by the preemption of state remedies under *Pilot Life* by providing a deterrent to bad faith behavior by plans and insurance contractors through the creation of a new ERISA remedy for fraud.

Under H.R. 1602, named fiduciaries and insurance contractors of employee welfare benefit plans are jointly and severally liable for failures to pay claims. The Committee recognizes that small employers with insured plans rarely are in a position to decide claims. In fact, in those situations, the insurer generally serves as claims fiduciary. The Committee initially considered making liable only those persons who bear ultimate responsibility for the claims decision. However, the Committee was concerned that the effect of such a rule would be to assure that every contract between an employer and an insurance contractor would contain a clause asserting that the plan sponsor had that sole responsibility, regardless of whether, in reality, the plan sponsor could exert any influence over what claims were paid. Notwithstanding the potential for joint and several liability, however, the Committee expects that a court, in examining the facts and circumstances of the case, would impose liability on the actual decisionmaker, taking into account the relative ability of each of the defendants to influence or control the decision.

If liability is established, the plaintiff may recover actual damages (including compensatory and consequential damages). When the Committee refers to compensatory damages (a term that is often used interchangeably with actual damages), it means the amounts needed to compensate a party for the legal wrong suffered because of a contract breach, and the amounts needed to restore the injured party as nearly as possible to his or her condition before the commission of a tort. Compensatory damages include both direct damages (those which result immediately from the complained of act) and consequential damages (losses resulting from special circumstances or conditions associated with the complained of act).

Punitive or exemplary damages may also be awarded in cases of fraud. However, a judge (and not a jury) must decide whether punitive damages ought to be awarded after fraud is determined and, if so, the amount of those damages. The Committee intends to rely on the definition of fraud taken from the model instructions to juries that Federal judges use. In brief, "fraud" means an intentional misrepresentation, deceit, or concealment of a material fact known to the defendant with the intention on the part of the defendant of thereby depriving a person of property or legal rights or otherwise causing injury.

One of the barriers to participants' ability to enforce their rights under ERISA is the difficulty in obtaining competent and affordable legal counsel. Currently, the awarding of attorney's fees is discretionary. In a substantial number of cases, fees are awarded. But questions have arisen about the circumstances under which attorney's fees ought to be provided and about whether expert witness fees may be awarded. Even if the participant is successful in his or her claims dispute, if fees are not paid, the participant may not even ultimately recover the face amount of the claim, because the attorney must still be compensated. Despite the popular myth of the greedy lawyer, there are some plaintiffs' attorneys who are reluctant to deny a participant who has been wronged a portion of the limited recovery available under ERISA. Having once been denied fees, these attorneys often will not take another ERISA case

and will warn their colleagues against taking them. ERISA is one of the few worker protection statutes that does not guarantee the payment of reasonable attorney's fees to successful claimants. H.R. 1602 corrects that problem by requiring the payment of reasonable attorney's fees and expert witness fees when the claimant prevails.

Finally, although H.R. 1602 as reported by the Committee generally rejects the approach taken in the originally introduced bill of restoring state unfair claims practices laws, the bill does clarify ERISA preemption of state law in two important but narrow respects.

First, the bill provides that states may establish or maintain beneficiary assistance programs to help resolve claims disputes between beneficiary assistance programs to help resolve claims disputes between beneficiaries and group health plans. The Committee recognizes that prior to the *Pilot Life* decision, state insurance departments provided invaluable consumer assistance, and the Committee is concerned that absent this clarification in ERISA, states may be hesitant to continue such assistance, fearing that their programs may be challenged under an overly broad reading of *Pilot Life.*

Second, the bill recognizes the right of states to license and regulate insurers, third-party administrators, and other insurance contractors when they provide administrative services to benefit plans. There have been disputes regarding the applicability of state licensure and business practices laws to insurance contractors, and the bill makes it clear that ERISA does not preempt state laws that require such contractors to be licensed or that provide for regulation of their business practices, claims settlement practices, financial status or related matters.

Congressional Budget Office Estimate

In compliance with clause 2(l)(3)(C) of rule XI of the Rules of the House of Representatives, the estimate with respect to H.R. 1602 prepared by the Congressional Budget Office pursuant to section 403 of the Congressional Budget Act of 1974, submitted prior to the filing of this report, is set forth as follows:

U.S. Congress,
Congressional Budget Office,
Washington, DC, September 21, 1992.

Hon. William D. Ford,
Chairman, Committee on Education and Labor,
House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the enclosed cost estimate of H.R. 1602, the Health Insurance Claims Fairness Act of 1992, as ordered reported by the Committee on Education and Labor on July 30, 1992.

This bill would affect direct spending and thus would be subject to pay-as-you-go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985. As a result, the estimate required under clause 8 of House Rule XXI also is enclosed.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

ROBERT D. REISCHAUER, *Director.*

Enclosure.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R. 1602.
2. Bill title: Health Insurance Claims Fairness Act.
3. Bill status: As ordered reported by the House Committee on Education and Labor on July 30, 1992.
4. Bill purpose: H.R. 1602 would amend title I of the Employee Retirement Income Security Act (ERISA) of 1974 to promote fairness in administration of health insurance and other claims under employee welfare benefit plans and to improve enforcement under such title with respect to such plans.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1993	1994	1995	1996	1997
Direct spending:					
Early resolution program:					
Estimated budget authority		1	1	2	3
Estimated outlays		1	1	2	3
Offsetting receipts:					
Estimated budget authority		−1	−1	−2	−3
Estimated outlays		−1	−1	−2	−3
Amounts subject to appropriation:					
Early resolution program:					
Estimated authorization level	(1)	1	1	2	2
Estimated outlays	(1)	1	1	2	2
Welfare benefits claims assistance program:					
Estimated authorization level	(1)	(1)	(1)	(1)	(1)
Estimated outlays	(1)	(1)	(1)	(1)	(1)
Study of preemption provisions:					
Estimated authorization level	(1)				
Estimated outlays	(1)				

[1] Less than $500,000.

Basis of estimate: *Early Resolution Program.*—H.R. 1602 would establish within the Department of Labor an Early Resolution Program for handling disputes concerning employee welfare benefit plans. As an alternative to litigation, the Early Resolution Program would perform mediation or arbitration for claimants who have exhausted all remedies under the process for the review of denied claims against a given benefit plan. Welfare benefits include medical, disability, death, or vacation benefits, but do not include pension benefits. Currently, the federal government does not provide this service.

The overall cost of running the program is estimated to be less than $500,000 in 1993, $2 million in 1994, $2 million in 1995, $4 million in 1996, and $5 million in 1997. The costs include expenses paid to the governing board (the Claims Resolution Board), salaries for administrative support staff, and compensation to arbitrators and facilitators. Part of these costs would be funded through the

collection of fees, which are discussed later in the estimate. The remaining costs are assumed to be funded through annual appropriations.

A Claims Resolution Board would administer the Early Resolution Program. This board would serve without pay. Reimbursement for travel and expenses is estimated to be $300,000 in 1993 and $100,000 each year from 1994 to 1997. The cost is greater the first year because the board would meet more frequently to set up the program. The program itself would begin to provide service one year after the enactment of the bill.

Further, the bill would provide for administrative staff and support services. The bill explicitly would provide for an executive director to be paid at the maximum rate for grade 14 of the federal general schedule for employee pay. However, the bill does not specify the number of staff to be hired. We assumed that the program would be implemented in the department's ten area offices. We estimate 2 full-time employees per office for 500 to 1,000 cases a year. In addition, we assume that the board would staff only half of the area offices at the outset and after two years operate in all ten. Figures on staffing levels compare to non-profit dispute resolution organizations currently in operation. Wages used in the estimate compare to average levels at the Pension and Welfare Benefits Administration.

Arbitrators and facilitators also would serve the program. The bill states that these individuals may elect to serve without pay or to receive a fixed fee. We estimate that the average cost of arbitrators and facilitators, including reimbursement for travel and expenses, would be $75 per hour reflecting the assumption that 50 percent of their services would be provided free of charge. Professionals in the field of dispute resolution say that some use of paid, experienced attorneys is necessary for quality assurance. In addition, we estimate the average time of service for a facilitator or arbitrator will be three hours per case.

Any estimate of caseload is uncertain because systematic, objective data on the number of benefit claims denied by plans are sparse. Most of the information currently available is anecdotal. However, the Administrative Office of the U.S. Courts reports 9,600 civil complaints involving ERISA claims in 1991. Some complaints go to court, while many are settled out of court. We estimate the number of claimants seeking resolution under the mediation process would be significantly less than this number at the outset of the program, would continue to grow as the program gains recognition, and would eventually exceed the number of cases filed in the U.S. courts. The number of cases going to arbitration are expected to comprise twenty percent of the total number of cases handled by the Early Resolution Program.

There are forces, though, which would act to drive down the number of claimants seeking the Early Resolution Program in the out years. First, there is some chance that the threat of binding arbitration, a component of the Early Resolution Program, could drive claimants and carriers to resolve disputes themselves. Second, the bill allows states to provide assistance to participants in the resolution of claims under group health plans or to regulate insurance contractors. Consequently, the exemption from ERISA

could prompt states to take measures to assist with dispute resolution and thus reduce the amount of service required of the federal program.

The cost for mediation would be offset by a $100 fee charged to both claimants and insurance plans. The cost of arbitration would be placed on the parties involved. If the claimant prevails in the arbitration proceeding, all the cost of arbitration would be paid by the opposing party. If the claimant does not prevail, the costs would be apportioned among all parties. This cost includes payment to the arbitrator. We estimate total fee collections to be zero in 1993, $1 million in 1994, $1 million in 1995, $2 million in 1996, and $3 million in 1997. While it is difficult to know if the fees are revenues or offsetting receipts, we have displayed them as offsetting receipts because they involve the payment of fees in return for certain specific services.

Welfare Benefit Claims Assistance Program.—H.R. 1602 would require the Department of Labor to establish a Welfare Benefit Claims Assistance Program. According to staff in the Department of Labor, much of the assistance mandated in the bill is already being provided by the Pension and Welfare Benefits Administration (PWBA). Yet, the bill would require some services, including the review of denied claims and assistance in appeals, that are beyond the scope of services currently provided by the PWBA. These additional services are estimated to cost less than $500,000 annually.

Study of Preemption Provisions.—H.R. 1602 also would require the Department of Labor to conduct a study and produce a report that would examine the effects of preemption provisions of ERISA together with any recommendations for legislative reform. ERISA preempts state laws that relate to pension and employee welfare benefit plans. The study would be completed one year after the enactment of the act.

Although the language is open to interpretation, we assume the study would not cover the total legal and economic effects of preemption. Based on this assumption, we estimate the cost to be $150,000 in fiscal year 1993.

6. Pay-as-you-go considerations: The Budget Enforcement Act of 1990 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts through 1995. The pay-as-you-go effects of the bill are as follows:

[By fiscal years, in millions of dollars]

	1992	1993	1994	1995
Outlays	0	0	0	0
Receipts	(1)	(1)	(1)	(1)

[1] Not applicable.

7. Cost to State and local governments: The bill could increase state costs for regulating and sanctioning insurance contractors or providing assistance in the resolution of claims. Yet, no estimate of these potential costs is possible. It would depend upon the amount of states that responded to the newly created ERISA exemption.

8. Estimate comparison: None.
9. Previous CBO estimate: None.
10. Estimate prepared by: Wayne Boyington.
11. Estimate approved by: C.G. Nuckols, Assistant Director for Budget Analysis.

CONGRESSIONAL BUDGET OFFICE ESTIMATE [1]

The applicable cost estimate of this Act for all purposes of sections 252 and 253 of the Balanced Budget and Emergency Deficit Control Act of 1985 shall be as follows:

[By fiscal years, in millions of dollars]

	1992	1993	1994	1995
Change in outlays	0	0	0	0
Change in receipts	(1)	(1)	(1)	(1)

[1] Not applicable.

Committee Estimate

With reference to the statement required by clause 7(a)(1) of rule XIII of the Rules of the House of Representatives, the Committee accepts the estimate prepared by the Congressional Budget office with respect to H.R. 1602.

Inflationary Impact Statement

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee estimates that the enactment of H.R. 1602 will have no inflationary impact on prices and costs in the operation of the national economy. It is the judgment of the Committee that the inflationary impact of this legislation as a component of the Federal budget is negligible.

Oversight Findings of the Committee

With reference to clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, the Committee's oversight findings are set forth in the Background and Need for the Legislation section of this report. No additional oversight findings are applicable at this time.

Oversight Findings and Recommendations of the Committee on Government Operations

In compliance with clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no findings or recommendations by the Committee on Government Operations were submitted to the Committee with reference to the subject matter specifically addressed in H.R. 1602.

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[1] An estimate of H.R. 1602, Health Insurance Claims Fairness Act, as ordered reported by the House Committee on Education and Labor on July 30, 1992. This estimate was transmitted by the Congressional Budget Office on September 21, 1992.

Section-by-Section Analysis of H.R. 1602, as Amended

SECTION 1.—SHORT TITLE

This section designates the bill as the "Health Insurance Claims Fairness Act of 1992."

SECTION 2.—IMPROVEMENTS IN CLAIMS PROCEDURE

In general, this section improves the current claims review process under section 503 of ERISA for employee welfare benefit plans, requires the Secretary of Labor to establish a welfare benefit claim assistance program for participants and beneficiaries under such plans, defines key terms, and imposes certain other requirements on such plans.

First, this section amends section 503 to establish a statutory claims review procedure for employee welfare benefit plans. Under current law, plans must provide participants an opportunity for a full and fair review of denied claims and written notice of claim denial, setting forth the specific reasons for the denial. Department of Labor regulations provide additional guidance to implement these requirements. 29 C.F.R. 2560.503–1 (1991).

Under the new statutory rules, a claim must be approved or denied in writing within 30 days of the date of submission of a complete claim. If the claim is denied, the claimant must be given written notice detailing the reasons for denial (including, if applicable, the medical basis for the determination and the process used to reach that conclusion) within five days after the date of the determination to deny the claim. As under current law, when a claim is initially denied, the notice must explain if additional information is required in order to perfect the claim, and the steps the claimant may take to obtain further review. Moreover, the claimant or his or her authorized representative must be given the opportunity to review and obtain pertinent documents, including insurance contracts with respect to the plan and fee or reimbursement schedules.

The claimant must have a period of at least 60 days from the date of denial to request reconsideration. However, if the claim is reasonably estimated to equal or exceed $10,000, reconsideration is automatic. This review must be de novo (without deference to previous findings and interpretations, and in light of whatever new information that the claimant may furnish). In addition, someone other than the initial reviewer but with authority to authorize payment of the claim must conduct the review. Finally, if the resolution of any of the issues involved requires medical expertise, the review must include review by a qualified physician. The Committee expects that any such qualified physician be a practicing physician of similar specialty who is licensed in the same state where the medical services were or will be provided.

Review must be completed within 30 days of the claimant's request for reconsideration except for claims involving services totaling at least $10,000, in which case the review must be completed within 30 days after the date the plan initially denied the request.

A special expedited procedure is established to consider certain claims or requests for preauthorization under group health plans. If the claim involves urgent treatment for life-threatening illness,

claims or requests for preauthorization must be approved or denied within 3 days. If the claim or request for preauthorization involves services which are reasonably estimated to total at least $20,000, the group health plan has 10 days to approve or deny the claim or request.

A previously authorized request or claim may not subsequently be denied, unless the plan proves that the claimant intentionally misrepresented a material fact when preauthorization was requested. These new claims procedures are applicable to claims filed after date of enactment.

In addition, this section prescribes additional notice and disclosure requirements for group health plans. If a claim is denied because the plan determines that the amount of the claim exceeds reasonable and customary charges, the notice must specify the factual basis for this determination. The Committee also expects that the information regarding the standard amounts of payments for these services be provided to participants in an easy-to-understand format. Similarly, if a claim is denied because the services provided were experimental or not medically necessary, the notice must specify the medical basis for this determination and the process the plan followed to reach that conclusion.

Third, section 2 of the bill explicitly prohibits employee benefit plans from requiring a participant to waive his or her rights under the plan or under ERISA as a condition for approval of any claim for benefits or preauthorization request, except when the waiver is part of a formal settlement agreement.

Fourth, section 2 requires the Secretary of Labor to establish a welfare benefit claims assistance program within 180 days after enactment.

Finally, the definition section of ERISA is amended to include several additional terms. Among them are the following:

(1) The term "insurance contractor" is defined as any insurer who has entered into a legally binding obligation to the plan or plan sponsor to provide benefits under the plan or to administer claims.

(2) The term "insurer" is defined as any person or legal entity engaged in the business of insurance, such as insurance companies, health maintenance organizations, or medical and hospital service plans. It also includes agents, adjusters, brokers and third party administrators. Utilization review entities are insurers under the bill. This definition was drawn from the model claims practices statute developed by the National Association of Insurance Commissioners.

SECTION 3.—EARLY RESOLUTION PROGRAM

Section 3 amends Part 5 of Title I of ERISA (relating to administration and enforcement) to create a new subpart B establishing an Early Resolution Program (ERP). The ERP is an alternative dispute resolution procedure available to participants in employee welfare benefit plans to provide faster, less costly methods of resolving claims disputes than can be obtained through court review. In general, under this section, participants have the option of choosing mediation or binding arbitration as alternatives to legal

action for disputes that are still unresolved after all plan appeals under section 503 of ERISA have been exhausted.

New subpart B consists of three chapters. Chapter 1 contains the general rules governing the program (including the establishment of the Claims Resolution Board), Chapter 2 contains the rules governing arbitration, and Chapter 3 relates to mediation.

A. General provisions

New Chapter 1 of Subtitle B of Part 5 of Title I of ERISA establishes an Early Resolution Program (ERP) for welfare benefit plans that is to be administered in the Department of Labor by a Claims Resolution Board (the Board). Notwithstanding the fact that the Board is administered within the Department, the Board is a completely independent policy making entity, not subject to control or direction by the Department.

The Board consists of six unpaid appointed members serving contemporaneous terms of three years with possible reappointment for one additional term. The Board's duties include administering the program, developing program policy and procedures, coordinating the recruitment, selection and training of facilitators and arbitrators, maintaining attorney referral panels, and continually monitoring and evaluating the program. In addition, the Board should develop a procedure to track cases so that the Board may identify case patterns, including situations in which (1) the same plan or insurance contractor is involved in a number of disputed cases, and (2) a number of cases involve the same type of dispute. The Board's administrative staff, provided by the Secretary of Labor, shall be headed by an Executive Director.

Disputes submitted to the ERP must be between a claimant for benefits under an employee welfare benefit plan and an insurance contractor or plan. The dispute may involve either a denied claim or a failure or refusal to supply the claimant with requested documents or information subject to disclosure under ERISA. Before participating in the ERP, the claimant must either receive a final determination regarding the claim under the plan's claims procedure under section 503 of ERISA or exhaust all remedies under the plan provided pursuant to section 503. A legal guardian or other court-appointed representative may represent the claimant if the claimant is unable to understand the program or its process. Welfare benefit plans must provide claimants with notice of the availability of the ERP.

Criteria for selecting arbitrators and facilitators are set forth in new ERISA section 523. In selecting such individuals, the Board must consider their experience in dispute resolution and in employee benefit law, their expertise pertaining to medical or disability issues, and their ability to act impartially. The Board is required to establish a training program which persons must complete prior to serving as arbitrators or facilitators.

Arbitrators and facilitators may serve on a pro bono basis or be compensated at a fixed fee that is established by the Board.

Parties may represent themselves or be represented by an attorney throughout the ERP proceedings. If a claimant is not represented by counsel, however, arbitrators and facilitators must make special efforts to assure that the rights of the claimant are protect-

ed during the process. In addition, the Committee expects that facilitators and arbitrators assist in case development with help from paid staff, since that is essential in maintaining the balance of power between the parties, particularly when the claimant is unpresented. The Board is required to maintain attorney referral panels of attorneys who are experienced in employee benefits law and who are willing to represent the individuals referred to them.

Generally, communications provided during the proceedings are confidential. New ERISA section 526 sets forth rules concerning the voluntary disclosure by arbitrators, facilitators, and parties to the ERP of information concerning communications that are provided during the proceedings. A civil penalty in the amount of three times the amount of the claim involved is provided when a violation of these rules occurs. In addition, an arbitrator or facilitator who violates this section is disqualified from subsequent participation in the program.

B. Arbitration of disputes

This section permits, at the claimant's election, claims disputes arising under employee welfare benefit plans to be resolved through binding arbitration. Within 60 days after the exhaustion of remedies under section 503, the claimant must elect arbitration. In the case of a claimant who first opted for mediation of the dispute and failed to achieve a settlement, the 60-day period begins when the mediation proceeding terminated.

In general, arbitration proceedings under new section 532 of ERISA are to be conducted in a manner similar to arbitration proceedings under Title 9 of the United States Code. However, to the extent that the statutory language in ERISA is in conflict with Title 9, the statutory language takes precedence.

The arbitrator must set the hearing date and not less than five days before the hearing, notify the parties of the date. A hearing record is not required to be printed, but may be, at the request of any party. The requesting party generally bears the cost, unless the parties agree otherwise or the arbitrator apportions costs. In the case of indigent claimants, the arbitrator may waive the costs of preparing a record.

Claimants are entitled to de novo review of their claim by the arbitrator. No deference shall be given to findings or interpretations of the plan or insurance contractor. The parties may present and the arbitrator may consider any oral or documentary evidence which is not irrelevant, immaterial, unduly repetitious, or privileged. The arbitrator is required to interpret and apply relevant statutory requirements and ensure that all applicable rights of the parties are protected. Findings of fact by the arbitrator are presumed correct. This presumption is rebuttable only by a clear preponderance of the evidence. Ex parte communication relevant to the merits of the case is not allowed unless the parties agree otherwise.

The arbitrator has 30 days after the close of the hearing, or the date of the filing of any brief authorized by the arbitrator, if later, to make an award. The award must include an informal discussion of the factual and legal basis for the award. The award becomes

final 30 days after it is served on all parties and is enforceable pursuant to Title 9 of the United States Code.

If the claimant prevails in arbitration, new ERISA section 532 requires the opposing party to pay the amount of the claim and reasonable attorney's fees and other costs of the proceeding including expert witness fees. If the claimant does not prevail, the costs of arbitration are apportioned among all parties. Any assessment against the claimant may be waived in whole or in part by the arbitrator.

In addition to these amounts, the arbitrator may assess additional penalties against an employee welfare benefit plan or insurance contractor in the amount of $10,000 for each of the following actions:

(1) by failing to act promptly on the claim, the liable party caused the exhaustion of section 503 remedies;

(2) the liable party misrepresented a material plan provision;

(3) the liable party refused to pay the claim without conducting a reasonable inquiry;

(4) the liable party failed to affirm or deny the availability of benefits within a reasonable time after having completed its inquiry related to the claim; or

(5) the liable party attempted to settle the claim, or attempted to compel the claimant to institute a proceeding to recover the amount of the claim by offering substantially less than the benefit amount ultimately recovered.

Finally, the section provides that actions for review of an arbitration award may be brought under Title 9 of the United States Code in Federal district court with appeal of the district court's order in the appropriate U.S. court of appeals.

C. Mediation of disputes

Under new ERISA section 541, a claimant may file an election with the Claims Resolution Board and enter into a written agreement to initiate mediation procedures under ERP. Upon a claimant's election, the plan or insurance contractor is required to participate in and cooperate fully with the mediation program. Each party must pay a $100 filing fee and is required to provide all relevant and requested documents to the facilitator assigned to the dispute by the Board.

New ERISA section 542 divides the mediation proceedings into two stages, the analysis stage and the evaluation stage.

During the analysis stage, the facilitator identifies the necessary parties, confirms that the case is eligible for mediation, ensures that each party is informed of available legal representation, sets a conference date, requests position papers from both parties if necessary, requests additional information if needed, and undertakes any case development which may be necessary.

During the evaluation stage, the facilitator convenes a conference in which both parties must be present. Each party must be given the opportunity to make an opening statement and to present additional evidence at the beginning of the conference. If a settlement is reached during the conference, the facilitator shall assist in drafting it and ensure that the parties understand the terms of the settlement; the settlement agreement shall remain

confidential at the parties' option. If no settlement is reached, the facilitator may assess for the parties the likely outcome of further administrative action or litigation. This evaluation shall be treated as confidential and is not admissible in any subsequent adjudicatory proceedings.

New section 543 of ERISA describes the time limits applicable to the mediation proceedings. In general, this section requires that the proceedings be completed within 120 days of the claimant's election to participate in the program.

New ERISA section 544 describes the legal effect of participation in mediation proceedings. In general, the findings and conclusions of the facilitator are advisory in nature and nonbinding. The rights of the parties are not affected as a result of their participating in this program unless the parties enter into a signed settlement agreement.

A settlement agreement is a contract enforceable under section 531 of ERISA (as added by this bill) and binding only on those persons who are party to the settlement. For purposes of Title I of ERISA, the terms of the settlement are treated as terms of the plan. New ERISA section 546 provides rule governing the enforcement of settlement agreements.

New ERISA section 545 describes the procedural rules applicable to mediation proceedings. This section makes it clear that formal rules of evidence do not apply in mediation proceedings and that all statements made and evidence presented are admissible. The facilitator has sole authority to determine the proper weight to be given to evidence.

D. Other provisions

Section 3 of the bill makes several other amendments to ERISA.

First, section 502 of ERISA (relating to civil enforcement) is amended so that the normal judicial remedies are not applicable to claims that have been arbitrated (except to the extent specifically provided for in new ERISA section 532) or to claims which have been settled through mediation with the adoption of a settlement agreement (except to the extent provided for in the agreement itself and to the extent specifically provided for in new ERISA section 546).

Second, the Board is authorized under section 502 of ERISA to collect civil penalties for failure to supply relevant plan documents as required by ERISA section 541(b)(2) (as added by this bill) or to provide additional information requested by the facilitator pursuant to ERISA (532(b)(6) (as added by this bill). The penalty for such failure or refusal is limited to $1,000 per day per failure or refusal.

Third, subsection (f)(3)(B) of section 3 provides that the provisions of section 3 do not apply to plans maintained pursuant to collective bargaining agreements between one or more employee organizations or one ore more employers if the plan is in effect on the date of enactment and the terms of the agreement include and continue to include specific provisions providing for resolution of claims disputes by arbitration, mediation, or both.

SECTION 4.—IMPROVEMENTS IN ENFORCEMENT

This section amends section 502 of ERISA to provide that if a claim for benefits under an employee welfare benefit plan is denied in violation of the terms of a plan or Title I of ERISA, or any provision of Title I is violated with respect to the administration or processing of a claim, the named fiduciary under the plan and any insurance contractor would be jointly and severally liable for actual damages (including compensatory and consequential damages proximately caused by the violation). In the case of fraud, a court (not a jury) could award punitive or exemplary damages. Although trustees of multiemployer plans would not be liable for the additional damages provided under section 4, insurance contractors, if any, of multiemployer plans would be.

This section also amends section 502 of ERISA to authorize civil actions by employers, employee organizations, and plans who are adversely affected by the failure of an insurance contractor or fiduciary to comply with the newly created claims procedures.

The amendments made by this section are effective for violations occurring or commencing on or after the enactment date of this Act.

SECTION 5.—ATTORNEY FEES AND COSTS OF ACTION

This section amends ERISA to provide that in any action or proceeding brought by a participant or beneficiary under Title I of ERISA in connection with any employee welfare benefit plan, in which the claimant prevails or substantially prevails, reasonable attorney's fees and other costs of the lawsuit, including reasonable expert witness fees must be paid. These fees are calculated at the generally prevailing hourly rates.

SECTION 6.—CLARIFICATION OF ABILITY OF STATES TO REGULATE THE BUSINESS OF INSURANCE

This section clarifies that ERISA does not preempt state laws that provide for state licensing or regulation of insurance contractors, state sanctions against insurance contractors for unfair claims settlement practices, or the establishment or maintenance of claim resolution programs by the state for claims arising under group health plans.

SECTION 7.—STUDY OF PREEMPTION PROVISIONS

This section requires the Secretary of Labor to conduct a study on the effects of ERISA's preemption of state laws relating to employee benefit plans. The study must be submitted to the relevant Congressional committees, together with legislative recommendations, not later than one year after date of enactment.

The Committee expects that the Secretary will examine the effect that preemption has had on competition, on segmentation of the marketplace, on participants' freedom of choice of licensed health care providers, on the creation of managed care networks and other employee pooling arrangements, and on the states' ability to protect consumers.

Changes in Existing Law Made by the Bill, as Reported

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Employee Retirement Income Security Act of 1974

SHORT TITLE AND TABLE OF CONTENTS

Section 1. This Act may be cited as the "Employee Retirement Income Security Act of 1974".

TABLE OF CONTENTS

Sec. 1. Short title and table of contents.

TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

Subtitle A—General Provisions

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Subtitle B—Regulatory Provisions

Part 1—Reporting and Disclosure

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Part 5—Administration and Enforcement

Subpart A—General Provisions

Sec. 501. Criminal penalties.
Sec. 502. Civil enforcement.

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Subpart B—Early Resolution Program

Chapter 1—General Provisions

Sec. 521. Establishment of the Early Resolution Program; Claims Resolution Board.
Sec. 522. Eligibility of cases for submission to Early Resolution Program.
Sec. 523. Arbitrators and facilitators.
Sec. 524. Compensation of arbitrators and facilitators.
Sec. 525. Role of attorneys.
Sec. 526. Confidentiality.

Chapter 2—Arbitration of Disputes

Sec. 531. Arbitration of claims disputes.
Sec. 532. Arbitration procedure.

Chapter 3—Mediation of Disputes

Sec. 541. Initiation of proceedings.
Sec. 542. The mediation proceedings.
Sec. 543. Applicable time limits.
Sec. 544. Legal effect of participation in proceedings.
Sec. 545. Procedural rules.
Sec. 546. Enforcement of settlement agreements.

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TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

Subtitle A—General Provisions

* * * * * * *

DEFINITIONS

SEC. 3. For purposes of this title:
(1) * * *

* * * * * * *

(42) GROUP HEALTH PLAN.—The term "group health plan" means an employee welfare benefit plan that provides health care benefits to participants or beneficiaries directly or through insurance, reimbursement, or otherwise.

(43) INSURANCE CONTRACTOR.—

(A) IN GENERAL.—The term "insurance contractor" for an employee welfare benefit plan means any insurer who has entered into a legally binding obligation to the plan or plan sponsor to provide benefits under the plan or to administer claims for such benefits.

(B) INSURER.—For purposes of subparagraph (A), the term "insurer" means any person or legal entity engaged in the business of insurance, including any insurance company, Lloyds insurer, fraternal benefit society, medical service plan, hospital service plan, health maintenance organization, prepaid limited health care service plan, and dental, optometric, or other similar health service plan. Such term shall include any agent, broker, or adjuster engaged by such a person or entity and any third party administrator engaged to administer benefit claims under an employee welfare benefit plan. For purposes of this title, all entities referred to in this subparagraph which are not employee benefit plans shall be deemed to be engaged in the business of insurance.

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Subtitle B—Regulatory Provisions

Part 1—Reporting and Disclosure

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FILING WITH SECRETARY AND FURNISHING INFORMATION TO PARTICIPANTS

SEC. 104. (a) * * *

(b) Publication of the summary plan descriptions and annual reports shall be made to participants and beneficiaries of the particular plan as follows:
(1) * * *

* * * * * * *

(4) The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary plan description, plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement,

contract, or other instruments under which the plan is established or [operated.] *operated, any insurance contract under which benefits are or were provided, and, in the case of a group health plan, any fee or reimbursement schedules for health care providers under the plan.* The administrator may make a reasonable charge to cover the cost of furnishing such complete copies. The Secretary may by regulation prescribe the maximum amount which will constitute a reasonable charge under the preceding sentence.

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Part 5—Administration and Enforcement

Subpart A—General Provisions

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civil enforcement

Sec. 502. (a) A civil action may be brought—

(1) by a participant or beneficiary—

(A) * * *

(B) to recover benefits due to him under the terms of his plan *or the provisions of this title*, to enforce his rights under the terms of the plan *or the provisions of this title*, or to clarify his rights to future benefits under the terms of the plan *or the provisions of this title*;

(2) by the Secretary, or by a participant, [beneficiary or fiduciary] *beneficiary, fiduciary, or plan* for appropriate relief under section 409 *or section 526(g)(2)*;

* * * * * * *

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title; [or]

(6) by the Secretary to collect any civil penalty under subsection (c)(2) or (i) or (l) *or section 526(g)(1)*[.]*;*

(7) by the Claims Resolution Board to collect any civil penalty under subsection (c)(4); or

(8) by an employer, an employee organization, or a plan for the relief provided under subsection (c)(5).

This subsection shall not apply with respect to a claim for benefits under an employee welfare benefit plan with respect to which arbitration proceedings are initiated under section 531. The applicability of this subsection to any claim shall not be affected by participation in mediation proceedings under chapter 3 of subpart B regarding such claim except to the extent otherwise required under the terms of any settlement agreement entered into in such proceedings.

* * * * * * *

(c)(1) * * *

* * * * * * *

(4) The Claims Resolution Board may assess a civil penalty against any party to any mediation proceeding under chapter 3 of

subpart B of this part of up to $1,000 a day from the date of such party's failure or refusal—

(A) to supply relevant plan documents or other additional information or documents as requested by the arbitrator in an arbitration proceeding under chapter 2 of subpart B, or

(B) to supply relevant plan documents as required under section 541(b)(2) or such additional information or documents as are requested by the facilitator pursuant to section 542(b)(6) in a mediation proceeding under chapter 3 of subpart B.

(5)(A) In any case in which a claim for a benefit under an employee welfare benefit plan is denied in violation of the terms of the plan or of this title or in which any provision of this title is violated with respect to the administration of the plan in connection with such a claim or the processing of such a claim thereunder, the named fiduciary under the plan and any insurance contractor for the plan administering such claim shall be jointly and severally liable to any participant, beneficiary, employer, employee organization, or plan aggrieved by such failure or violation for actual damages (including compensatory and consequential damages proximately caused by such failure or violation), except that, subject to subparagraph (B), damages for such failure or violation shall not include punitive damages.

(B) In any case in which a failure or violation described in subparagraph (A) constitutes fraud, each party liable under subparagraph (A) may, in the court's discretion, be liable to the plaintiff for punitive or exemplary damages in addition to damages described in subparagraph (A).

(C) A named fiduciary under a multiemployer plan shall not be liable under this paragraph.

(D) The remedies provided under this paragraph shall be in addition to remedies otherwise provided under this section.

* * * * * * *

(e)(1) Except for actions under [subsection (a)(1)(B) of this section] *paragraph (1)(A) (with respect to relief under subsection (c)(5)), paragraph (1)(B), or paragraph (7) of subsection (a),* the district courts of the United States shall have exclusive jurisdiction of civil actions under this title brought by the Secretary or by a participant, beneficiary, or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under [subsection (a)(1)(B) of this section] *paragraph (1)(A) (with respect to relief under subsection (c)(5)), paragraph (1)(B), or paragraph (7) of subsection (a).*

* * * * * * *

(g)(1) In any action under this title (other than an action described in paragraph (2) *or (3)*) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

* * * * * * *

(3) In any action or settlement proceeding under this title with respect to an employee welfare benefit plan by a participant or beneficiary under such plan in which the participant or beneficiary prevails or substantially prevails, the participant or beneficiary shall

be entitled to reasonable attorney's fees and other costs of the action, including reasonable expert witness fees, to be paid by the opposing party. Fees to which the participant or beneficiary is entitled under this paragraph shall be at generally prevailing hourly rates.

* * * * * * *

CLAIMS PROCEDURE

SEC. 503. *(a) IN GENERAL.*—In accordance with regulations of the Secretary, every employee benefit plan [shall]—

(1) *shall* provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, [and]

(2) *shall* afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim[.], *and*

(3) may not require any party to waive any right under the plan or this Act as a condition for approval of any claim for benefits under the plan, or any request for preauthorization of services under the plan, except to the extent otherwise specified in a formal settlement agreement.

Any waiver described in paragraph (3) shall be null and void unless such waiver is included in a formal settlement agreement. The terms of any settlement agreement entered into under the procedures established by an employee welfare benefit plan pursuant to this subsection shall be enforceable under this title as if such terms were terms of the plan.

(b) CLAIMS REVIEW REQUIREMENTS FOR EMPLOYEE WELFARE BENEFIT PLANS.—An employee welfare benefit plan shall not be treated as complying with the requirements of subsection (a) unless such plan complies with the following requirements:

(1) TIME LIMIT FOR CONSIDERATION OF COMPLETED CLAIMS.—An employee welfare benefit plan shall provide to any participant or beneficiary claiming benefits under the plan a written notice of the plan's approval or denial of the claim within 30 days after submission of the claim in complete form. In any case in which the claim is denied, the plan shall, within 5 days after the date of the determination to deny the claim, provide the claimant with a written notice setting forth the reasons for the denial, together with notice of the right to appeal the denial under paragraph (2).

(2) PLAN'S DUTY TO REVIEW DENIALS UPON TIMELY REQUEST.—The plan shall review its denial of the claim if—

(A) the claimant submits to the plan a written request for reconsideration of the claim after receipt of written notice from the plan of the denial, or

(B) the claim involves services the aggregate value or expected aggregate value of which is reasonably estimated to exceed $10,000.

The plan shall allow the claimant not less than 60 days, after receipt of written notice from the plan of the denial, to submit the claimant's request for reconsideration of the claim.

(3) TIME LIMIT FOR REVIEW.—The plan shall complete any review required under paragraph (2), and shall provide written notice of the plan's decision on the claim after reconsideration pursuant to such review—

(A) before 30 days after receipt of the request for reconsideration, in any case described in paragraph (2)(A), or

(B) before 30 days after the date of the initial determination, in any case described in paragraph (2)(B).

(4) DE NOVO REVIEWS.—Any review required under paragraph (2)—

(A) shall be de novo,

(B) shall be conducted by an individual who did not make the initial decision denying the claim and who is authorized to approve payment of the claim, and

(C) shall include review by a qualified physician if the resolution of any issues involved requires medical expertise.

(c) TREATMENT OF REQUESTS TO GROUP HEALTH PLANS FOR PREAUTHORIZATION.—

(1) IN GENERAL.—This subsection applies in the case of any request by a participant or beneficiary, or by any person on behalf of a participant or beneficiary, for preauthorization of services which is submitted to a group health plan prior to receipt of such services and which involves—

(A) urgent treatment for a life-threatening illness, or

(B) services the aggregate value or expected aggregate value of which is reasonably estimated to total at least $20,000.

(2) SHORTENED TIME LIMIT FOR CONSIDERATION OF REQUESTS FOR PREAUTHORIZATION.—Notwithstanding subsection (b)(1), a group health plan shall approve or deny any request for preauthorization described in paragraph (1) before 10 days (3 days if the request involves urgent treatment for a life-threatening illness) after submission of the request to the plan.

(3) AUTOMATIC REVIEW.—The plan shall review any determination to deny a request for preauthorization described in paragraph (1) before 3 days after the date of the initial determination. Any such review shall be conducted in accordance with the requirements of subsection (b)(4) as if the request were a claim to which such subsection applies.

(4) EXPEDITED EXHAUSTION OF PLAN REMEDIES.—Upon completion of the review required under paragraph (3), the request for preauthorization shall be treated as a claim with respect to which all remedies under the plan provided pursuant to this section are exhausted for purposes of further action under this part.

(5) DENIAL OF PREVIOUSLY AUTHORIZED CLAIMS NOT PERMITTED.—In any case in which a group health plan approves the request of any person for preauthorization described in paragraph (1)—

(A) the plan may not subsequently deny any claim by such person for such services, unless the plan makes a

showing of intentional misrepresentation by such person of a material fact, and

(B) if the claim is denied by the plan in violation of subparagraph (A), all remedies under the plan provided pursuant to this section with respect to such claim shall be treated as exhausted for purposes of further action on the claim under this part.

(d) TIME LIMIT FOR DETERMINATION OF INCOMPLETENESS OF CLAIM.—For purposes of this section, a claim for benefits under an employee welfare benefit plan shall be treated as filed in complete form as of 10 days (3 days in any case in which the claim involves urgent treatment for a life-threatening illness) after the date of the submission of the claim, unless the plan provides to the claimant, within such period, a written notice of any required matter remaining to be filed in order to complete the claim. Any filing of matter requested by the plan pursuant to this paragraph shall be treated for purposes of this section as an initial filing of the claim.

(e) ADDITIONAL NOTICE AND DISCLOSURE REQUIREMENTS FOR GROUP HEALTH PLANS.—In the case of a denial of a claim for, or a request for preauthorization of, benefits under a group health plan—

(1) if the denial is based in whole or in part on a determination that the claim or request exceeds reimbursement rates based on reasonable and customary charges, the notice provided pursuant to subsection (a)(1) shall set forth the factual basis for such determination,

(2) if the denial is based in whole or in part on exclusion of coverage with respect to services because such services are determined to comprise an experimental treatment or investigatory procedure, such notice shall set forth the medical basis for such determination and a description of the process used in making such determination, and

(3) if the denial is based in whole or in part on a determination that the treatment is not medically necessary, such notice shall set forth the medical basis for such determination and a description of the process used in making such determination.

(f) WELFARE BENEFIT CLAIMS ASSISTANCE PROGRAM.—The Secretary shall establish by regulation a welfare benefit claims assistance program. Under the program, the Secretary shall make available to participants and beneficiaries under employee welfare benefit plans ongoing assistance in the resolution of claims under such plans. Such assistance shall include, but not be limited to, reviewing denials of claims, assisting in appeals, contacting employee welfare benefit plans and insurance contractors on behalf of participants and beneficiaries, assisting participants and beneficiaries in obtaining plan documents, and referring of cases for appropriate enforcement action.

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EFFECT ON OTHER LAWS

SEC. 514. (a) * * *

(b)(1) * * *

* * * * * * *

(9) Subsection (a) shall not apply to any provision of State law to the extent that such provision—

(A) provides for the establishment or maintenance of any program making available to participants and beneficiaries ongoing assistance in the resolution of claims under group health plans, or

(B) provides for the licensing or regulation of insurance contractors or provides sanctions against insurance contractors for unfair claims settlement practices.

* * * * * * *

Subpart B—Early Resolution Program

CHAPTER 1—GENERAL PROVISIONS

SEC. 521. ESTABLISHMENT OF THE EARLY RESOLUTION PROGRAM; CLAIMS RESOLUTION BOARD.

(a) ESTABLISHMENT OF PROGRAM.—The Secretary shall establish and maintain an Early Resolution Program for employee welfare benefit plans, which shall be administered in the Department of Labor by a Claims Resolution Board (hereinafter in this subpart referred to as the "Board").

(b) IN GENERAL.—The Board shall—

(1) administer the Early Resolution Program in accordance with regulations of the Board,

(2) develop Program policy and procedures,

(3) maintain a roster of arbitrators to act for the Board in arbitration proceedings under chapter 2, and coordinate the recruitment, selection, and training of such arbitrators,

(4) maintain a roster of facilitators to act for the Board in mediation proceedings between parties conducted under chapter 3, and coordinate the recruitment, selection, and training of such facilitators,

(5) provide meeting sites, maintain records, and provide arbitrators and facilitators with administrative support staff,

(6) establish and maintain attorney referral panels, and

(7) monitor and evaluate the Program on an ongoing basis.

(c) MEMBERSHIP.—The Board shall consist of qualified attorneys or other professionals appointed by the Secretary who have expertise in the area of welfare benefits. The members shall serve for contemporaneous terms of 3 years and may be reappointed for one additional term. Vacancies for any term shall be filled for the remainder of such term in the same manner as the original appointment. Of the members of the Board—

(1) 2 members shall represent the interests of employee welfare benefit plans and insurance contractors,

(2) 2 other members shall represent the interests of plan participants and beneficiaries, and

(3) the remaining 2 members shall be experienced in mediation, conciliation, and arbitration procedures.

No member of the Board may otherwise serve as an employee of the United States, any State, or any political subdivision of a State. Not more than 3 members shall be of the same political party. Members of the Board shall serve without pay, except that each member shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code. The Board shall elect one member to serve as Chairman.

(d) EXECUTIVE DIRECTOR AND STAFF.—The Secretary shall provide the Board with such administrative staff and support services as the Secretary considers necessary and appropriate. The administrative staff shall be headed by an Executive Director appointed by the Board. The Executive Director shall serve as the chief executive officer of the Board and in such capacity shall, with the assistance of such staff, conduct case intake under the Program and otherwise assist the Board in carrying out its functions. The Executive Director shall be paid at the rate equivalent to the maximum rate for GS–14 of the General Schedule.

(e) QUORUM.—Four members of the Board shall constitute a quorum necessary for business, and four affirmative votes shall be necessary for action.

SEC. 522. ELIGIBILITY OF CASES FOR SUBMISSION TO EARLY RESOLUTION PROGRAM.

(a) CASE CRITERIA.—A dispute may be submitted to the Early Resolution Program only if the following requirements are met with respect to such dispute:

(1) PARTIES.—The dispute consists of an assertion by an individual of one or more claims, based on alleged coverage as a participant or beneficiary under an employee welfare benefit plan, against the plan, one or more insurance contractors for such plan, or both, and a denial of such claims, or a denial of appropriate reimbursement based on such claims, by such plan, any such insurance contractor, or both.

(2) NATURE OF CLAIM.—Each claim consists of—

(A) a claim for benefits under the plan of the type described in section 3(1); or

(B) a claim arising out of the failure or refusal by the plan or by an insurance contractor for the plan to comply with the claimant's request for information or documents the disclosure of which is required under this title (including any claim of entitlement to disclosure based on colorable claims to rights to benefits under the plan).

(3) SUBMISSION AFTER EXHAUSTION OF PLAN REMEDIES AND IN LIEU OF COMMENCEMENT OF CIVIL ACTION.—The claimant has received a final determination regarding the claim under the plan's claims procedure under section 503, or has otherwise exhausted all remedies under the plan provided pursuant to section 503, and no action has been commenced by the claimant under section 502 asserting a claim which is asserted by the claimant in the dispute.

(b) REPRESENTATION IN CASES OF INCOMPETENCY.—Any claimant who is unable to have a basic understanding of the Program or its process may be represented during the proceedings by a legal guardian or other court-appointed representative.

(c) NOTICE OF PROGRAM AVAILABILITY.—Each employee welfare benefit plan shall provide, as part of its claims review procedure established pursuant to section 503(a), that claimants taking part in such procedure will be informed during such procedure of the availability of the Early Resolution Program.

SEC. 523. ARBITRATORS AND FACILITATORS.

(a) RECRUITMENT.—The Board shall recruit individuals to serve as arbitrators and facilitators under the Early Resolution Program from individuals who have the requisite expertise for such service.

(b) CRITERIA.—In selecting individuals to serve as arbitrators or facilitators, the Board shall consider the following:

(1) the individual's experience in dispute resolution.

(2) the individual's ability to act impartially;

(3) the individual's ability to perform evaluations quickly and to present them in nontechnical terms; and

(4) the individual's experience in employee benefit law and, to the extent that the individual's service will relate to group health plans, the individual's expertise pertaining to medical or disability issues;

(c) TRAINING OF ARBITRATORS AND FACILITATORS.—The Board shall provide a training program for all new arbitrators and facilitators. The curriculum shall include the procedures of the Program, relevant ethical obligations, and skills in arbitration, mediation, and conciliation necessary for effective alternative dispute resolution in the applicable proceedings. An arbitrator or facilitator may serve only upon completion of such training program.

(d) ASSIGNMENT OF ARBITRATORS AND FACILITATORS TO CASES.—Upon submission of a claim to arbitration proceedings under chapter 2 or mediation proceedings under chapter 3, the Board shall appoint an arbitrator or facilitator (as appropriate) through a random selection procedure which shall be prescribed in regulations of the Board.

SEC. 524. COMPENSATION OF ARBITRATORS AND FACILITATORS.

Arbitrators and facilitators serving in the Early Resolution Program may, at their election, serve on a pro bono basis or be compensated at a fixed fee to be established by the Board. The Board shall provide for additional compensation for follow up proceedings. Each arbitrator and facilitator shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

SEC. 525. ROLE OF ATTORNEYS.

(a) REPRESENTATION.—Parties may participate pro se or be represented by attorneys throughout the arbitration and mediation proceedings under the Early Resolution Program.

(b) REFERRALS.—The Board shall maintain attorney referral panels (both fee-paying and pro bono) and referral information regarding other sources of legal assistance. Such panels shall consist of attorneys who are experienced in relevant employee benefit law and willing to represent the parties referred to them.

SEC. 526. CONFIDENTIALITY.

(a) ARBITRATORS AND FACILITATORS.—Except as provided in subsections (d) and (e), an arbitrator or facilitator in a proceeding

under the Early Resolution Program shall not voluntarily disclose or through discovery or compulsory process be required to disclose any information concerning any proceeding communication or any communication provided in confidence to the arbitrator or facilitator, unless—

(1) all parties to the proceeding and the arbitrator or facilitator consent in writing, and, if the proceeding communication was provided by a nonparty participant, that the participant also consents in writing,

(2) the proceeding communication has already been made public,

(3) the proceeding communication is required by statute to be made public, but an arbitrator or facilitator may make such communication public only if no other person is reasonably available to disclose the communication, or

(4) a court determines that such testimony or disclosure is necessary to—

(A) prevent a manifest injustice,

(B) help establish a violation of law, or

(C) prevent harm to the public health or safety,

of sufficient magnitude in the particular case to outweigh the integrity of the proceedings in general by reducing the confidence of parties in future cases that their communications will remain confidential.

(b) PARTIES.—A party to a proceeding under the Early Resolution Program shall not voluntarily disclose or through discovery or compulsory process be required to disclose any information concerning any proceeding communication, unless—

(1) the communication was prepared by the party seeking disclosure,

(2) all parties to the proceeding consent in writing,

(3) the proceeding communication has already been made public,

(4) the proceeding communication is required by statute to be made public,

(5) a court determines that such testimony or disclosure is necessary to—

(A) prevent a manifest injustice,

(B) help establish a violation of law, or

(C) prevent harm to the public health or safety,

of sufficient magnitude in the particular case to outweigh the integrity of the proceedings in general by reducing the confidence of parties in future cases that their communications will remain confidential,

(6) the proceeding communication is relevant to determining the existence or meaning of an agreement or award that resulted from the proceeding or to the enforcement of such an agreement or award, or

(7) the proceeding communication was provided to or was available to all parties to the proceeding.

(c) INADMISSIBILITY OF DISCLOSED INFORMATION.—Any proceeding communication that is disclosed in violation of subsection (a) or (b) shall not be admissible in any proceeding relating to the issues in controversy with respect to which the communication was made.

(d) ALTERNATIVE PROCEDURES.—The parties may agree to alternative confidential procedures for disclosures by an arbitrator or facilitator. Upon such agreement the parties shall inform the arbitrator or facilitator before the commencement of the proceeding of any modifications to the provisions of subsection (a) that will govern the confidentiality of the proceeding. If the parties do not so inform the arbitrator or facilitator, subsection (a) shall apply.

(e) NOTICE OF DEMANDS FOR DISCLOSURE.—If a demand for disclosure, by way of discovery request or other legal process, is made upon an arbitrator or facilitator regarding a proceeding communication, the arbitrator or facilitator shall make reasonable efforts to notify the parties and any affected nonparty participants of the demand. In any case in which such disclosure would otherwise be in violation of this section, the arbitrator or facilitator may perform such disclosure in accordance with such demand only if each party and affected nonparty participant who receives such notice consents to such disclosure within 15 calendar days after the date of the issuance of such notification.

(f) EXCEPTIONS.—

(1) INFORMATION OTHERWISE DISCLOSABLE.—Nothing in this section shall prevent the discovery or admissibility of any evidence that is otherwise discoverable, merely because the evidence was presented in the course of a proceeding under the Early Resolution Program.

(2) DOCUMENTATION OF AGREEMENTS OR ORDERS.—Subsections (a) and (b) shall have no effect on the information and data that are necessary to document an agreement reached or order issued pursuant to a proceeding under the Early Resolution Program.

(3) RESEARCH OR EDUCATIONAL PURPOSES.—Subsections (a) and (b) shall not prevent the gathering of information for research or educational purposes so long as the parties and the specific issues in controversy are not identifiable.

(4) DISPUTES BETWEEN ARBITRATOR OR FACILITATOR AND A PARTY.—Subsections (a) and (b) shall not prevent use of a proceeding communication to resolve a dispute between the arbitrator or facilitator in a proceeding under the Early Resolution Program and a party to or participant in such proceeding, so long as such proceeding communication is disclosed only to the extent necessary to resolve such dispute.

(g) CIVIL REMEDIES.—

(1) CIVIL PENALTY.—The Secretary may assess a civil penalty against any person who discloses information in violation of subsection (a) or (b) in the amount of three times the amount of the claim involved.

(2) DISQUALIFICATION FROM SERVICE.—Any arbitrator or facilitator who discloses information in violation of subsection (a) shall be disqualified from further service as an arbitrator or facilitator under this subpart.

(h) DEFINITIONS.—For purposes of this section—

(1) PROCEEDING COMMUNICATION.—The term "proceeding communication" means any oral or written communication prepared for the purposes of a proceeding under the Early Resolution Program, including any memoranda, notes, or work prod-

uct of the arbitrator or facilitator, parties, or nonparty participants, except that such term does not include a written agreement to enter into the proceeding or a final written agreement or arbitral award reached as a result of the proceeding.

(2) IN CONFIDENCE.—The term "in confidence" means, with respect to information, that the information is provided—

(A) with the expressed intent of the source that it not be disclosed, or

(B) under circumstances that would create the reasonable expectation on behalf of the source that the information will not be disclosed.

CHAPTER 2—ARBITRATION OF DISPUTES

SEC. 531. ARBITRATION OF CLAIMS DISPUTES.

Any dispute between a participant or beneficiary and an employee welfare benefit plan, an insurance contractor for such a plan, or both, which is eligible under section 522 for submission to the Early Resolution Program may be resolved through arbitration under this chapter at the election of the claimant. The claimant may initiate the arbitration proceedings under this chapter only by filing with the Board a written election within the 60-day period following (1) the date on which all remedies under section 503 with respect to the claim on which the dispute is based have been exhausted or (2) if mediation proceedings are commenced under chapter 3 with respect to the claim, the date on which such mediation proceedings are terminated without entering into a settlement agreement with respect to the claim.

SEC. 532. ARBITRATION PROCEDURE.

(a) IN GENERAL.—An arbitration proceeding under this chapter shall be conducted by arbitrators recruited, trained, and assigned by the Claims Resolution Board under section 523 and in accordance with fair and equitable procedures to be prescribed by the Board which shall be subject to the requirements of this chapter. Any arbitration proceedings under this chapter shall, to the extent consistent with this subpart, be conducted in the same manner, subject to the same limitations, and carried out with the same powers (including subpoena power) as an arbitration proceeding carried out under title 9, United States Code, as if entered into pursuant to agreement by the parties.

(b) SPECIFIC RULES.—

(1) NOTICE.—The arbitrator shall set a time and place for the hearing on the dispute and shall notify the parties not less than 5 days before the hearing.

(2) RECORD.—Any party wishing a record of the hearing shall—

(A) be responsible for the preparation of such record,

(B) notify the other parties and the arbitrator of the preparation of such record,

(C) furnish copies to all identified parties and the arbitrator, and

(D) pay all costs for such record, unless the parties agree otherwise or the arbitrator determines that the costs should be apportioned.

(3) PROCEDURE.—

(A) The parties to the arbitration proceeding are entitled to be heard, to present evidence material to the controversy, and to have such evidence considered on a de novo basis.

(B) The hearing shall be conducted expeditiously and in an informal manner.

(C) The arbitrator may receive any oral or documentary evidence, except that irrelevant, immaterial, unduly repetitious, or privileged evidence may be excluded by the arbitrator.

(D) The arbitrator shall interpret and apply relevant statutory and regulatory requirements and relevant legal precedents and shall ensure that all applicable rights of the parties are protected.

(c) TREATMENT OF EX-PARTE COMMUNICATIONS.—No party shall make or knowingly cause to be made to the arbitrator an unauthorized ex parte communication relevant to the merits of the proceeding, unless the parties agree otherwise. If a communication is made in violation of this subsection, the arbitrator shall ensure that a memorandum of the communication is prepared and made a part of the record, and that an opportunity for rebuttal is allowed. Upon receipt of a communication made in violation of this subsection, the arbitrator may, to the extent consistent with the interests of justice and the policies underlying this chapter, require the offending party to show cause why the claim of such party should not be resolved against such party as a result of the improper conduct.

(d) FINDINGS OF FACT BY ARBITRATOR.—There shall be a presumption, rebuttable only by a clear preponderance of the evidence, that the findings of fact made by the arbitrator in the arbitration proceeding were correct.

(e) ARBITRATOR'S AWARD.—

(1) ISSUANCE.—The arbitrator shall make the award in an arbitration proceeding under this chapter within 30 days after the close of the hearing, or the date of the filing of any briefs authorized by the arbitrator, whichever date is later, unless the parties agree to some other time limit. The award shall include a brief, informal discussion of the factual and legal basis for the award, but formal findings of fact or conclusions of law shall not be required. The award shall become final 30 days after it is served on all parties.

(2) AMOUNTS AWARDED.—In any case in which the claimant prevails in the arbitration proceedings, the arbitrator shall award to the claimant the amount of the claim (including reasonable interest) and reasonable attorney's fees and other costs of the proceedings, including reasonable expert witness fees, to be paid by the opposing party or parties, and shall assess all costs of the arbitration, other than costs otherwise provided for under subsection (b)(2), to the other party. Fees awarded under this paragraph shall be at generally prevailing hourly rates. In any case in which the claimant does not prevail, the costs of the arbitration, other than costs otherwise provided for under subsection (b)(2), shall be apportioned among all parties, except that any assessment against the claimant may be waived in whole or in part in the discretion of the arbitrator.

(3) ADDITIONAL PENALTIES.—

(A) IN GENERAL.—In any case described in subparagraph (B), an employee welfare benefit plan or insurance contractor which is ordered to pay health benefits required under the terms of the plan as part of an arbitration award issued under this chapter may, in the arbitrator's discretion, be liable to the participant or beneficiary aggrieved by the failure of the plan to pay such benefits, in addition to damages described in subparagraph (A), in an amount not to exceed $10,000 for each instance described in subparagraph (B).

(B) CASES IN WHICH PENALTIES APPLY.—Subparagraph (A) shall apply in any case in which the arbitrator determines that the liable party—

(i) caused the exhaustion of remedies under section 503 by means of failing to act on the claim in a timely manner in violation of such section,

(ii) misrepresented a material plan provision to the participant or beneficiary,

(iii) refused to pay the claim without conducting a reasonable inquiry in a case where an inquiry is reasonably required,

(iv) failed to affirm or deny the availability of benefits within a reasonable time after having completed its inquiry related to the claim, or

(v) attempted to settle the claim, or attempted to compel the participant or beneficiary to institute the action under this section to recover the amount of the claim, by offering to the participant or beneficiary substantially less than the benefit amount ultimately recovered.

(C) PENALTIES IN ADDITION TO OTHER AMOUNTS AWARDED.—The remedies provided under this paragraph shall be in addition to amounts otherwise awarded under this subsection.

(4) ENFORCEMENT.—A final award is binding on the parties to the arbitration proceeding, and may be enforced pursuant to sections 9 through 13 of title 9, United States Code.

(5) PRECEDENTIAL EFFECT OF ARBITRATION AWARDS.—An award entered in an arbitration proceeding under this chapter may not be used as precedent or otherwise be considered in any factually unrelated proceeding, whether conducted under this chapter, by an agency, or in a court, or in any other arbitration proceeding.

(f) JUDICIAL REVIEW.—Notwithstanding any other provision of law, any person adversely affected or aggrieved by an award made in an arbitration proceeding conducted under this chapter may bring an action for review of such award only pursuant to the provisions of sections 9 through 13 of title 9, United States Code. An appeal may be taken to the appropriate United States court of appeals from an order of a United States district court confirming or denying confirmation of an arbitrator's award made under this subpart or modifying, correcting, or vacating such an award.

CHAPTER 3—MEDIATION OF DISPUTES

SEC. 541. INITIATION OF PROCEEDINGS.

(a) FILING OF ELECTION.—A claimant with a dispute which is eligible under section 522 for submission to the Early Resolution Program and which is not subjected to arbitration pursuant to an election under chapter 2 may elect to participate in such proceedings with respect to such dispute by means of filing with the Board an election for mediation under this chapter. A dispute may be submitted to the mediation proceedings under this chapter only if such dispute consists of an assertion by an individual of one or more claims, based on alleged coverage as a participant or beneficiary under an employee welfare benefit plan, against the plan, an insurance contractor for the plan, or both, and a denial of such claims by the plan or the insurance contractor. An election to commence proceedings under this chapter shall be in such form and manner as the Board may prescribe by regulation.

(b) AGREEMENT TO PARTICIPATE.—

(1) ELECTION BY CLAIMANTS.—A claimant may elect participation in mediation proceedings under this chapter only by entering into a written agreement (including an agreement to comply with the rules of the Program and consent for the Board to contact the employee welfare benefit plan and any insurance contractor involved regarding the agreement), by releasing plan records to the Program for the exclusive use of the facilitator assigned to the mediation, and by paying to the Board a nonrefundable filing fee of $100. Such fee shall be deposited as miscellaneous receipts in the general fund of the Treasury and is hereby appropriated solely for purposes of administering this chapter. The fee may be waived in cases of hardship, under standards which shall be prescribed by the Board by regulation.

(2) PARTICIPATION BY PLANS AND INSURANCE CONTRACTORS.—Each party whose participation in the mediation proceedings has been elected by a claimant pursuant to paragraph (1) shall participate in, and cooperate fully, in the proceedings. The Board shall provide each such party with a copy of the participation agreement described in paragraph (1), together with a written description of mediation under the Early Resolution Program. Each such party shall submit such copy of the agreement, together with such party's authorized signature signifying receipt of notice of the agreement, to the Board, shall include in such submission to the Board a copy of the written record of the claims procedure completed by the plan or insurance contractor pursuant to section 503 with respect to the dispute and all relevant plan documents, and shall pay the Board a nonrefundable filing fee of $100. Such fee shall be deposited as miscellaneous receipts in the general fund of the Treasury and is hereby appropriated solely for purposes of administering this chapter. The relevant documents shall include all documents under which the plan is or was administered or operated, including copies of any insurance contracts under which benefits are or were provided and, in the case of a group health plan, any fee or reimbursement schedules for health care providers requested by the facilitator.

SEC. 542. THE MEDIATION PROCEEDINGS.

(a) IN GENERAL.—A mediation proceeding under this chapter shall be conducted by facilitators recruited, trained, and assigned by the Board under section 523 and in accordance with fair and equitable procedures to be prescribed by the Board which shall be subject to the requirements of this chapter.

(b) ANALYSIS STAGE.—In the commencement of the mediation proceedings with respect to any dispute, the facilitator assigned to the dispute shall—

(1) identify the necessary parties,

(2) confirm that the case is eligible for mediation under this chapter,

(3) ensure that each party is informed of available legal representation, including such services as may be available free of charge under legal assistance programs,

(4) set a conference date,

(5) at the option of the facilitator, request position papers from the parties of not more than 10 pages in length, if the facilitator determines that such papers are needed to clarify the parties' positions and issues in dispute, and

(6) analyze the record of the claims procedure conducted pursuant to section 503 and any position papers submitted by the parties, with appropriate legal assistance provided by the Secretary, to determine if further case development is needed to clarify the legal and factual issues in dispute, and whether there is any need for additional information and documents, and request the parties to present any such needed information and documents.

(c) EVALUATION STAGE.—Upon completion of the procedures described in subsection (b), the mediation proceedings shall proceed as follows:

(1) COMMENCEMENT OF CONFERENCE.—The facilitator shall convene a conference between the parties. Each party shall be given the opportunity to make a statement summarizing the facts, issues, and arguments in support of such party's position, and present, or inform the facilitator of, any additional evidence such party considers to be relevant to the evaluation.

(2) NEUTRALITY OF FACILITATOR.—The facilitator shall maintain a neutral stance between the parties.

(3) PREPARATION OF SETTLEMENT AGREEMENT.—If settlement is reached, the facilitator shall assist in the preparation of a written settlement agreement (which shall remain confidential at the option of the parties) and shall ensure that the parties understand the terms of the settlement.

(4) EVALUATION UPON INITIAL FAILURE TO REACH SETTLEMENT.—If no settlement is reached, the facilitator may evaluate for the parties the likely outcome of further administrative action or litigation, based on the facilitator's assessment of the relative strength of each party's position. Any such evaluation by the facilitator shall be treated as a proceeding communication to which section 526 applies.

(5) FURTHER PROCEEDINGS.—The facilitator shall then encourage extension of the proceedings if it is likely to lead to settlement or a substantial narrowing of the issues.

SEC. 543. APPLICABLE TIME LIMITS.

(a) IN GENERAL.—The mediation proceedings under this chapter with respect to any dispute shall be completed within 120 days after the election to participate, as follows:

(1) PRESENTATION TO PLANS AND INSURANCE CONTRACTORS OF CLAIMANT'S SIGNED AGREEMENT.—The Board shall present to each party whose participation in the mediation proceedings has been elected by the claimant the agreement signed by the claimant within 10 days after the date of the claimant's signature.

(2) SUBMISSION OF RECEIPT BY PLANS AND INSURANCE CONTRACTORS.—Each party whose participation in the mediation proceedings has been elected by the claimant shall submit within 20 days after receipt of the signed agreement its authorized signature signifying receipt of the notice of the agreement.

(3) ASSIGNMENT OF FACILITATOR.—The facilitator shall be assigned to the case within 30 days after the date as of which all necessary authorized signatures have been secured.

(4) COMPLETION OF ANALYSIS STAGE.—The facilitator shall complete all procedures required in the analysis stage described in section 542(a) within 45 days after the facilitator's assignment to the case.

(5) COMMENCEMENT OF EVALUATION STAGE.—The conference conducted under the evaluation stage described in section 542(b) shall commence not later than the earlier of 60 days after the date of the assignment of the facilitator or 15 days after completion of the analysis stage described in section 542(a).

(b) EXTENSION OF PROCEEDINGS.—The parties may agree to one extension of the proceedings of not more than 30 days.

SEC. 544. LEGAL EFFECT OF PARTICIPATION IN PROCEEDINGS.

(a) PROCESS NONBINDING.—Findings and conclusions made in the mediation proceedings under this chapter shall be treated as advisory in nature and nonbinding. Except as provided in subsection (b), the rights of the parties under subpart A shall not be affected by participation in the mediation proceedings under this chapter.

(b) RESOLUTION THROUGH SETTLEMENT AGREEMENT.—If a case is settled through participation in the mediation proceedings under this chapter, the facilitator shall assist the parties in drawing up an agreement which shall constitute, upon signature of the parties, a binding contract between the parties, which shall be enforceable under section 546, and which shall be enforceable under this title as if the terms of such agreement were terms of the plan.

(c) PRESERVATION OF RIGHTS OF NON-PARTIES.—The settlement agreement shall not have the effect of waiving or otherwise affecting any rights to review under section 502 or any other right under this title or the plan with respect to any person who is not a party to the settlement agreement.

SEC. 545. PROCEDURAL RULES.

(a) INAPPLICABILITY OF FORMAL RULES OF EVIDENCE.—Formal rules of evidence shall not apply to mediation proceedings under this chapter. All statements made and evidence presented in the proceedings shall be admissible in such proceedings. The facilitator

shall be the sole judge of the proper weight to be afforded to each submission.

(b) INAPPLICABILITY OF OATH REQUIREMENTS.—The parties to the mediation proceedings under this chapter shall not be required to make statements or present evidence under oath.

SEC. 546. ENFORCEMENT OF SETTLEMENT AGREEMENTS.

(a) CONFIRMATION; JURISDICTION; PROCEDURE.—At any time within one year after the date of a settlement agreement entered into under this chapter any party to the agreement may apply to the United States district court in and for the district within which such agreement was made for an order confirming the agreement. Upon such application, the court shall grant such an order unless the agreement is vacated, modified, or corrected as prescribed in subsection (b) or (c). Notice of the application shall be served upon the adverse party. Upon such notice, the court shall have jurisdiction of such adverse party as though such adverse party had appeared generally in the proceeding. If the adverse party is a resident of the district within which the award was made, such service shall be made upon the adverse party or such party's attorney as prescribed by law for service of notice of motion in any action in the same court. If the adverse party is a nonresident, the notice of the application shall be served by the marshal of any district within which the adverse party may be found in like manner as other process of the court.

(b) VACATION; GROUNDS; REHEARING.—The court may make an order vacating the settlement agreement upon the application of any party to the agreement if—

(1) the agreement was procured under duress or by corruption, fraud, or undue means, or

(2) there was evident partiality or corruption in the facilitator who assisted in the making of the agreement.

(c) MODIFICATION OR CORRECTION; GROUNDS; ORDER.—The court may make an order modifying or correcting the settlement agreement upon the application of any party to the agreement if—

(1) there was a material miscalculation of figures or a material mistake in the description of any person, thing, or property referred to in the agreement,

(2) the agreement relates to a matter not submitted in the conference proceedings, unless it is a matter not affecting the merits of the agreement upon the matter submitted, or

(3) the agreement is imperfect in matter of form not affecting the merits of the controversy.

The order may modify and correct the agreement, so as to effect the intent thereof and promote justice between the parties.

(d) NOTICE OF MOTIONS TO VACATE OR MODIFY; SERVICE; STAY OF PROCEEDINGS.—Notice of a motion to vacate, modify, or correct a settlement agreement made under this subpart must be served upon the adverse party or the party's attorney within 90 days after the settlement agreement is made. If the adverse party is a resident of the district within which the agreement is made, such service shall be made upon the adverse party or the party's attorney as prescribed by law for service of notice of motion in an action in the same court. If the adverse party is a nonresident, the notice of the application

shall be served by the marshal of any district within which the adverse party may be found in like manner as other process of the court. For the purposes of the motion any judge who may make an order to stay the proceedings in an action brought in the same court may make an order, to be served with the notice of motion, staying the proceedings of the adverse party to enforce the agreement.

(e) PAPERS FILED WITH ORDER ON MOTIONS; JUDGMENT; DOCKETING; FORCE AND EFFECT; ENFORCEMENT.—

(1) FILING OF PAPERS.—The party moving for an order confirming, modifying, or correcting a settlement agreement made under this chapter shall, at the time such order is filed with the clerk for the entry of judgment thereon, also file the following papers with the clerk:

(A) the agreement, and

(B) each notice, affidavit, or other paper used upon an application to confirm, modify, or correct the agreement, and a copy of each order of the court upon such an application.

(2) DOCKETING OF JUDGMENT.—The judgment shall be docketed as if it were rendered in an action.

(3) FORCE AND EFFECT; ENFORCEMENT.—The judgment so entered shall have the same force and effect, in all respects, as a judgment in an action, and shall be subject to all the provisions of law relating to such a judgment. Such judgment, including the terms of the agreement (as confirmed, modified, or corrected), may be enforced as if it had been rendered in an action in the court in which it is entered.

(f) APPEALS.—An appeal may be taken from an order confirming or denying confirmation of a settlement agreement made under this chapter or modifying, correcting, or vacating such an agreement.

PART 6—CONTINUATION COVERAGE UNDER GROUP HEALTH PLANS

* * * * * * *

SEC. 607. DEFINITIONS AND SPECIAL RULES.

For purposes of this part—

[(1) GROUP HEALTH PLAN.—The term "group health plan" means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise.]

(1) GROUP HEALTH PLAN.—For the definition of "group health plan", see section 3(42).

* * * * * * *

MINORITY VIEWS

We oppose H.R. 1602, as described below, because the bill as reported is duplicative and overreaching in its effect, is unfair in its application, and raises troubling questions of constitutionality. By promoting litigation and uncapped damages, the bill will unnecessarily raise the costs of coverage under ERISA plans providing health care, day care, pensions, scholarships, job training, and life and disability insurance. While adequate remedies under ERISA are necessary, in our opinion these employee benefits are too important to the welfare of America's workers and their families for us to support legislation which will diminish coverage and create a confusing and costly array of disincentives for employers to establish and maintain ERISA employee pension and welfare benefit plans.

I. H.R. 1602 Weakens the Preemption Cornerstone of ERISA

As originally introduced and reported, without amendment, by the Subcommittee on Labor-Management Relations, H.R. 1602 was written to exempt from ERISA preemption any statutory or common law of a state which provides remedies against insurers who engage in unfair insurance claims practices. The purported purpose of this language was to overturn the decision of the Supreme Court in *Pilot Life* v. *Dedeaux*, 481 U.S.41 (1987).

In *Pilot Life* the Court held that causes of action under state decisional common law—in this case, the Mississippi law of bad faith—do not fall under ERISA's insurance "savings" clause, and thus are not excepted from the federal preemption of state law. The court reasoned that a common-sense understanding of the language of the saving clause excepting from preemption a state law that "regulates insurance" does not support the argument that the Mississippi law of bad faith falls under the clause. The court found that to "regulate" insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry.

The court also stated that the language, structure, and legislative intent concerning ERISA's civil enforcement provisions support the conclusion that they were intended to provide exclusive remedies for ERISA plan participants and beneficiaries who assert the improper processing of benefit claims. In particular, the court observed that:

> ERISA's detailed provisions set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be

completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. The conclusion that ERISA's civil enforcement provisions were intended to be exclusive is also confirmed by the legislative history of those provisions, particularly the history demonstrating that the preemptive force of ERISA's enforcement provisions was modeled after the powerful preemptive force of Section 301 of the Labor-Management Relations Act.

The court is thus in agreement with the original authors of the landmark legislation, including Rep. John Dent who served as the floor manager for ERISA from this Committee when he stated the case for the broadest possible preemption of state laws as follows:

> Finally, I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority [of] the *sole power* to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation. (emphasis added)

However, it is this very "conflicting and inconsistent" state and local regulation which the provisions of H.R. 1602, both as introduced and reported by the Committee, would allow to be imposed on ERISA plans. As reported, section 6 of the bill exempts from ERISA preemption "any provision of state law to the extent that such provision—(A) provides for the establishment or maintenance of any program making available to participants and beneficiaries ongoing assistance in the resolution of claims under group health plans, or (B) provides for the licensing or regulation of insurance contractors or provides *sanctions* against insurance contractors for unfair claims settlement practices" (emphasis added).

State remedies inconsistent or nonexistent

Whether intended or not, "sanctions" against insurance contractors for unfair claims settlement practices could be read to include tort cases involving bad faith claims denials in some states, but not in others. Also, uncapped or capped punitive damages may be among the remedies available under the common law in some states, but not others. State statutory remedies may also vary considerably in this area.

The application of such a set of inconsistent standards would mean that some plan participants could avail themselves of remedies involving considerable damages, while to others the remedies available would remain unclear or be nonexistent. Different remedies for participants covered under the same plan is clearly not what the framers of ERISA had in mind in promoting effective and fair protections for employee benefit plan participants and beneficiaries.

Bill creates an open door for further confusion

While state law remedies overturned by *Pilot Life* vary considerably, in addition to restoring these remedies to ERISA plans the bill presents an open door to the proliferation of statutory and

other inconsistent remedies, and even the inconsistent interpretation among the states of similar or identical remedies.

Under the bill, the scope of such remedies could be applied to any ERISA pension or welfare benefit plan which has a connection to an "insurance contractor". Again, the definition of insurance contractor is defined so broadly as to open up new venues for non-uniform state action. For example, the term includes not just insurance companies, but inter alia HMOs; dental, optometric, and prepaid limited health service plans; third party administrators; and, agents, brokers, adjusters, etc. Since, typically, the health and other ERISA plans maintained by small businesses are fully insured, the added costs of the punitive damages and other remedies allowed under state law will fall heavily on the small business community and their employees.

The term "unfair claims settlement practice" is not defined in the bill, thus creating further uncertainty whether this term will have one meaning or a different meaning in each jurisdiction in which a suit is brought.

It is also unclear what is intended by exempting from preemption "any provision of State law to the extent such provision * * * provides for the licensing or regulation of insurance contractors." Since the insurance savings clause under ERISA already preserves the state regulation of insurance, this provision appears unnecessary. By interjecting the term "insurance contractor", the bill also unnecessarily clouds the meaning of "insurance" in the context of ERISA preemption.

Duplicate remedies leads to question of constitutionality

Given that the substitute adopted by the Committee includes an expansive new and elaborate scheme of claims remedies and damages under ERISA (as discussed below), it is unclear what is intended by also retaining the essence of the original bill language which overturns the *Pilot Life* decision.

Certainly, these two disparate and conflicting federal and state approaches will not result in the uniformity of application which Rep. John Dent called the "crowning achievement of ERISA."

To the contrary, this duplicative scheme of federal and state law remedies raises serious practical questions by creating the opportunity for multiple and concurrent actions in both federal and state courts. Besides further clogging an already overburdened court system, this may well result in a perpetually unsettled system of law and a confusing array of conflicting interpretations.

As troubling is the possibility that third-party administrators and other insurance contractors could be held liable for duplicative penalties for the same action under both state law and the ERISA federal law. By imposing multiple liability for the same action, the civil equivalent of double jeopardy, past precedent suggests that it is possible that some affected parties will raise questions of constitutionality under the Fifth Amendment due process clause of the Constitution. For example, see *Juzwin* v. *Antorg Trading Corp.*, 705 F. Supp. 1053 (D.N.J. 1989) and 718 F. Supp. 1233, 1234 (D.N.J. 1989).

II. Scope of Bill Far Exceeds Showing of Need

The hearings held by the Subcommittee on Labor-Management Relations on H.R. 1602 focused on the *Pilot Life* decision and the claims payment problems experienced by a relatively small number of individuals in connection with their participation under ERISA covered hospital, medical, and disability plans. Most of the evidence presented, which was largely anecdotal, involved the narrow, albeit important, issue of whether particular procedures were properly denied under plan provisions excluding payments for "experimental treatments". In this regard, it might be noted that an amendment offered by the Minority specifically addressed this issue by requiring an expedited full review of requests for preauthorization.

In contrast, the committee amendment introduces radical new remedies which are applied not just to "experimental treatments" or medical, hospital, or disability plans, but to all ERISA "welfare benefit plans". No evidence has been presented to justify the bill's expansive claims processing and remedial scheme as it would be applied to ERISA plans providing day care, legal services, vacations, scholarships, training, housing, and death and unemployment benefits. In fact, the issue of remedies applicable to pension plans was never discussed, even though the committee substitute would apparently allow state law sanctions in connection with insured pension plans.

While the type of plan targeted by the substitute far exceeds the object of the debate, the ERISA remedies included in the substitute engender a similar overreaching effect. In fact, the substitute language, including the complex arbitration and mediation process, and the vast new potential for unlimited damages, was unveiled at the markup without the benefit of a public record of hearings and comment.

III. Excessive Damages Will Ruin Health of Benefit Plans

Under section 4 of the substitute, except for multiemployer plans, the named fiduciary of each ERISA welfare benefit plan and the related "insurance contractor", if any, are made jointly and severally liable for unlimited actual damages (including compensatory and consequential damages) as well as for unlimited punitive damages in the case of fraud. The scope of this provision goes well beyond any demonstrated need, raises serious constitutional questions, and will result in numerous harmful effects on the health of the voluntary system of ERISA health and welfare plans.

Tort-like remedies replace ERISA contract remedies

For the first time under ERISA, the substitute introduces medical malpractice-like tort remedies for claimants under nearly every type of ERISA health and welfare benefit plan. Today the ERISA claims process primarily involves disputes over contract provisions, e.g. whether a claim was denied because it was excluded from the plan as an uncovered expense.

In contrast, the bill interjects uncapped "pain and suffering", "emotional distress", and other subjective damages into the health and welfare benefits claims process which will likely generate the

same kinds of excessive jury awards which have so plagued our Nation's health care system. In addition, the substitute allows punitive damages to be assessed in whatever unlimited amount a court might decide.

These remedies apply not just to health plans, but to day care, training, housing, legal services, and every other type of ERISA welfare benefit plan. The scope of the new ERISA remedies, therefore, far exceeds the narrow topic of the hearings on H.R. 1602, which focused primarily on the denial of certain claims as being "experimental treatments". In fact, the state law remedies intended to be restored under H.R. 1602 by reversing *Pilot Life* do not contain punitive damages in most cases, are limited mainly to insurers, and generally require a showing of "bad faith" before they can be applied.

Escalation in health plan costs and defensive claims practices will result

By subjecting plans, employers, insurers, and others to increased litigation, punitive, compensatory, and extracontractual damages, and mandatory attorney and witness fees, it appears that the substitute will create situations in which the fear of litigation and the possibility of large damage awards will cause plan administrators to pay claims for benefits which, in fact, may not be actually provided under the plan.

Eventually, the likely effect will be that health care and other plans will be more strictly drawn so that they included only scheduled dollar benefits and exclude any remotely questionable procedure in order to avoid questions which might lead to costly or crippling litigation. Thus, the potential of a damage award bonanza for the few will translate into a curtailment of coverage for the many who now have benefits.

Of course, to the extent that particular claimants are successful in receiving multimillion dollar or other large awards, these costs will be passed along by the plans to the employers or employees, who ultimately must bear the costs of ERISA benefit programs. The mere uncertainty of the incidence and amount of such damage awards can also be expected to raise the already high costs of health care as insurers increase their premiums to cover these newly anticipated costs.

Just as the medical malpractice crisis has driven up the cost of health care through the practices of "defensive medicine", plans and insurers can also be expected to engage in what might be called "defensive claims practices". To avoid expensive litigation, it can be anticipated that plans and insurers will also begin paying questionable claims which would have previously been denied. New approaches to managing and controlling rapidly escalating health care costs will also be discouraged.

In the final analysis, the financial exposure to unlimited damages will greatly discourage employers from voluntarily providing health and other employee welfare benefits. The chief beneficiaries of the increased opportunity for litigation would appear to be lawyers who can receive both hourly and contingency fees in such situations.

Small Business and named fiduciaries put at risk

In connection with the unlimited damage remedies, the substitute puts at risk, jointly, both named fiduciaries and insurance contractors.

In the case of small business plans, it is likely that the proprietor or owner will be the "named fiduciary" under the plan. Even one large damage award levied against a small business or its owner could be financially devastating. This raises a serious question as to how likely it will be for such businesses to continue their health, disability, life insurance, and other plans in the face of such catastrophic risks? Certainly, any such employer contemplating putting in such a plan would be greatly discouraged from doing so. It would be more advantageous for employers to pay cash and let employees obtain their own insurance than to expose their entire business or personal assets to an unlimited risk of loss.

Liability without fault raises questions of constitutionality

Even if a small business retains an "insurance contractor" to help provide coverage, the risk to the business cannot be avoided because of the joint and several liability. For example, an insurer could be found solely at fault for denying a claim, but the small business person would still be held liable. The reverse can also be the case, for example when the named fiduciary of a large single-employer plan makes the final decision to deny a claim which the administering insurer recommends be paid.

Thus, the committee substitute makes named fiduciaries or insurance contractors liable for the actions of others over whom they may have no control. By imposing liability without any finding of either fault or causation, the bill raises troubling questions of fairness and constitutionality under the due process clause of the Fifth Amendment. For example, see e.g., *Mulcahy* v. *Eli Lilly & Co.,* 386 N.W. 2d 67, 76 (Iowa 1986); *Zafft* v. *Eli Lilly & Co.,* 676 S.W. 2d 241, 246–47 (Mo. 1984); *Pippon* v. *Burroughs-Wellcome Co.,* 532 F. Supp. 637, 639 (D.N.J. 1982); *Namm* v. *Charles E. Frosst & Co.,* 427 A.2d 1121, 1129 (N.J. App. 1981).

Furthermore, the substitute does not appear to provide such liable persons with a cause of action under ERISA for contribution or indemnification against the person who may have been the sole or primary cause of the violation resulting in damages. Because the Supreme Court has held that ERISA's remedial scheme is exclusive, this omission may serve to deny persons without fault the ability to recover, thus raising additional questions of fairness and due process.

Multiemployer plan exclusion raises questions of fairness and constitutionality

Excluded from liability under the damages provision are the named fiduciaries under multiemployer plans. In general, the named fiduciaries under these union-negotiated plans are the joint labor-management board of trustees.

Proponents try to justify this exception by stating that individuals are willing to serve as unpaid trustees only if the plan obtains errors and omissions insurance to protect them from personal li-

ability, but that such indemnity insurance is not available for the punitive remedies being proposed. Of course, the same can be said for the named fiduciaries of any plan whether insured or self-insured, large or small, and whether collectively-bargained or not. By including this exclusion the substitute gives clear recognition to the significant additional costs of providing punitive and related damages as a remedy.

The effect of this exclusion, of course, is to provide different remedies to similarly situated participants depending upon whether they are a union sponsored multiemployer plan or a single-employer plan. This disparate treatment raises a serious issue of equal protection of the law under the Fifth Amendment (e.g. see *McBride* v. *General Motors Corp.* 737 F. Supp. 1563 (M.D. Ga. 1990)).

Furthermore, exempting multiemployer plan fiduciaries from liability for damages while holding similarly situated single-employer plan fiduciaries liable for such damages may raise similar questions of constitutionality under the equal protection clause.

IV. New Claims Procedures Costly, Unfair, and Unproven

The committee substitute changes the current, and already substantial, ERISA claims process and adds several new layers of complexity.

Arbitrary changes made to current substantive procedures

The Supreme Court described ERISA's current remedies as a comprehensive scheme which represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging plan formation. Under ERISA section 503 and pursuant to regulations, claims must be processed within 90 days, and, if denied, the responsible fiduciary is required to give the specific reasons and plan provisions supporting the denial. If a claim is finally denied after the application of a required appeals procedure, the claimant may sue to enforce the plan and obtain the denied benefits, to obtain reasonable attorney's fees, to remove the plan fiduciary, and to obtain other equitable relief. Other enforcement actions and penalties may apply in the case of certain fiduciary breaches and interference with participant rights.

Unfortunately, the many infirmities of the substitute will serve to undermine the "careful balancing" referred to by the Supreme Court. For example, the more restrictive time limits for considering and appealing claims are also applied under the bill across the board to all welfare benefit plans without taking into account the differences among the variety of health, disability, legal services, death and unemployment benefit plans, etc. In addition, conceivably the bill could be read to require nearly every medical and disability claim to be reviewed by a "qualified physician" within a tight time frame. Is this feasible or even possible, and at what cost?

The bill also requires that the terms of a claims settlement agreement be enforceable as are the terms of the plan. Would this apply only to the person affected or could this set a plan precedent which would undermine the terms of the plan established through collective bargaining or otherwise? Certainly plan fiduciaries would

be discouraged from entering into extracontractual compromise settlements, thus encouraging litigation over resolution.

These are only some of the troubling questions that are raised by the bill's ambiguous, loose, and overreaching language. Because of the new procedural hurdles and disincentives to settle, the bill will have the likely effect of slowing down the payment of those routine claims which now are paid in a timely fashion and within the new time periods required under the bill.

Bill created duplication and costly bureaucracy

In addition to allowing legal service, insurance department, or other claims assistance programs to operate under state law, the bill mandates the Secretary of Labor to establish a duplicate claims resolution program. The cost and extent of this program could be substantial given the ability of participants to engage assistance even before they have exhausted their own plan's claims processing and appeals procedure.

This assistance program is in addition to the arbitration and mediation procedures the Department is directed to establish under the bill's "early resolution program". These programs are to be administered by a new six member Board with its own Executive Director and staff. The Board is directed to assemble and train a large number of arbitrators and mediation facilitators, all of whom can be paid for their time and expenses.

The Department will also have to provide locations across the country for resolution proceedings and provide such other offices, staff, and support services as may be necessary.

Given that the 130 million participants and their beneficiaries in the over 4.5 million ERISA employee welfare benefit plans can access this program, it is likely that the cost of this program will reach substantial proportions shortly after its initiation. While certain forms of claims mediation or arbitration may prove to be both fair and cost effective, the bill's duplicative and open-ended approach, leaving substantial incentives for subsequent litigation does not appear to offer a workable solution.

The bill does not say how the substantial costs of these new programs will be paid, or whether this will be achieved either through increased revenues or reduced spending in other areas.

Resolution programs unlikely to stem litigation

If the intent of the bill's arbitration and mediation program is to speed the process of claims dispute resolution and reduce the chance for litigation, then these worthy goals will be left largely unfulfilled because of the shortcomings of the program mechanisms.

For example, mediation is not offered as an alternative to litigation, but instead is constructed so as to be available either prior to litigation or prior to arbitration (which could itself become the subject of litigation). Whether intended or not, the mediation process, with a requirement for findings and conclusions, could be exploited as a form of pre-trial or pre-arbitration discovery, thus increasing costs and discouraging speedy claims resolution.

Also, the use of the arbitration process by claimants is undercut by the availability of unlimited compensatory and punitive dam-

ages if, instead, litigation is pursued. Under the assumption that such damages are not available in arbitration, how likely will it be that claimants' lawyers will recommend arbitration when litigation offers the potential for large damages and related contingency fees?

Arbitration raises other questions

Unlike typical arbitration proceedings in the employee benefits and labor area, the bill allows the claimant to unilaterally invoke binding arbitration. The arbitrator would not be mutually selected by the parties, but appointed by the Board within the Department of Labor.

Also, the bill provides that arbitration proceedings are to be conducted in an "informal manner" and that in making an award the arbitrator include "a brief, informal discussion of the factual and legal basis for the award, but without formal findings of fact or conclusions of law." Also, a record of the hearings is not required, unless requested and paid for by one of the parties to the arbitration proceedings.

While a judicial review of these proceedings is permitted, the "informal" nature of the procedure raises a number of questions. For example, on what standard is an arbitrator expected to award penalties of up to $10,000 on each of five counts? Because of this lack of explicit or implied standard to which an arbitrator can refer or be judged, it may well be that parties unfairly charged will raise arguments that this provision violates rights of due process.

Ambiguous language in subsection (e)(3) stating that the $10,000 arbitration penalties are "in addition to damages", raises a serious question of whether or not the unlimited compensatory and punitive damages available in litigation may also be awarded in arbitration.

Exemption for collectively bargained plans is unfair

As offered in committee, the substitute exempts certain collectively-bargained plans from all of the requirements of the mediation and arbitration provisions of the early resolution program. As originally drawn, the provision could be interpreted to exclude all collectively-bargained plans as long as they comply with the existing claims resolution procedure under ERISA section 503.

Even if this exemption is narrowed to include additional criteria, the differing treatment of collectively-bargained plans, the effect of which is to deny union employees and their families the same remedies as non-union workers, seems unfair, if not unconstitutional.

V. Conclusion

To address a relatively narrow problem involving the payment of certain ERISA health plan claims, the committee has reported a bill both sweeping in scope and radical in its effect. Any real and specific health claims payment problems that may have been identified can and should be addressed under ERISA. However, they should be addressed in a specific and problem solving manner and not include tort-like punitive and other damages, the costs of which will result in fewer benefits and fewer benefit plans. In this regard, we might note that efforts by the Minority to improve the ERISA

claims process and develop an appropriate and workable resolution program was defeated by the Majority.

When it comes to health care, it is clear that America's workers want access to a fairly administered plan providing adequate benefits in connection with their employment, and they want it to be affordable. The committee bill offers not a solution, but a step backward in meeting this goal by encouraging more litigation and holding out the carrot of uncapped damage awards.

The Supreme Court stated that the ERISA enforcement scheme represents a careful balancing of the need for prompt and fair claims settlement procedures versus the public interest in encouraging the formation of employee benefit plans. In conclusion, we agree with the Supreme Court that this careful balancing must be maintained, and therefore we must oppose the committee bill with its imbalance, numerous faults, and serious questions of constitutionality.

BILL GOODLING.
TOM PETRI.
MARGE ROUKEMA.
STEVE GUNDERSON.
RICHARD K. ARMEY.
HARRIS W. FAWELL.
PAUL B. HENRY.
CASS BALLENGER.
SUSAN MOLINARI.
BILL BARRETT.
JOHN A. BOEHNER.
SCOTT KLUG.
MICKEY EDWARDS.
RANDY "DUKE" CUNNINGHAM.

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